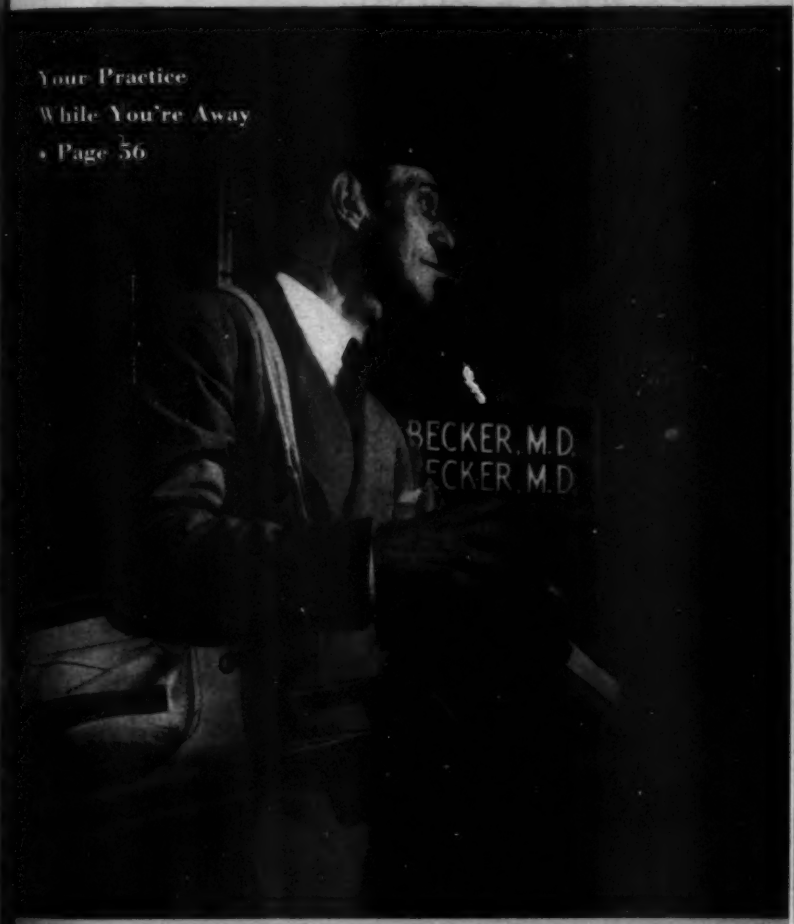
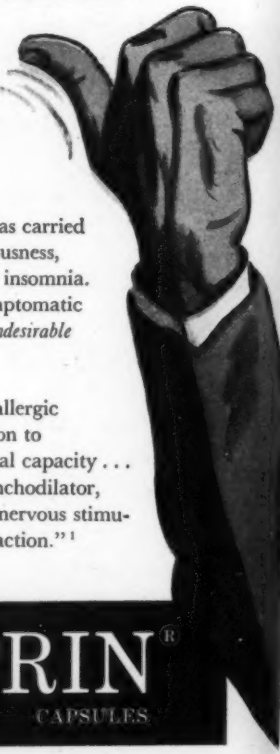
May Medical Economics



Must side effects hitchhike

with effective relief in bronchial asthma?



For years, relief in bronchial asthma has carried unwelcome side effects with it—nervousness, palpitation, increased blood pressure, insomnia. But now, Nethaprin makes prompt, symptomatic relief possible—*essentially free from the undesirable side actions of Ephedrine.*

In bronchial asthma and synonymous allergic conditions, Nethaprin can be relied upon to provide effective relief . . . increased vital capacity . . . better feeling of well-being. Yet its bronchodilator, Nethamine, "causes very little central nervous stimulation and produces little or no pressor action."[1]

NETHAPRIN®

SYRUP CAPSULES

Merrell
1828
CINCINNATI • U. S. A.

Each capsule and 5 cc. teaspoonful contains: Nethamine® 25 mg., Butaphyllamine® 60 mg., Decapryn® Succinate 6 mg.

When Phenobarbital is desired, NETHAPHYL.® In full or half strength.

1. Hansel, F. K.: Ann. Allergy, 5:397, 1947.

Accurate on the spot

Hb Determination

Widespread acceptance of the Spencer Hb-Meter proves that physicians need this means of obtaining *laboratory* accuracy in hemoglobin determination *in less than 3 minutes.*

Only the Hb-Meter permits:

- ★ Complete portability
- ★ Results in grams per 100ml or a choice of percentage scales
- ★ Hemolysis of blood without dilution
- ★ Accurate determinations by persons with deficient color vision
- ★ Matching field within the spectral region of maximum visual sensitivity

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CHICAGO, ILLINOIS

Medical Economics

• • • *May 1950* • • •

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

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NATOLONE

now available

the steroid hormone of choice

in rheumatoid arthritis

now available

NATOLONE (Δ^5 pregnenolone)

is indicated in the treatment of rheumatoid arthritis because of its therapeutic efficacy and its absence of toxicity. Clinical investigators have shown that Natolone possesses definite advantages over other hormonal therapy in arthritis and related conditions.

Therapeutic Dose: 200 mg. to 300 mg. per day orally, increased if indicated, up to 500 mg. per day. Oral dosage may be supplemented by one or two doses of 100 mg., deep intramuscularly, each week.

Maintenance Dose: An oral dose of 50 mg. daily may be sufficient to maintain improvement.

Supplied as coated tablets of 50 mg. each of Pregnenolone Acetate and Injectosols (Multiple Dose Vials) 9 cc. of pregnenolone, 100 mg. per cc.

Comprehensive literature available on your request

NATOLONE

(brand of Δ^5 pregnenolone)

a product of

The National Drug Company

Philadelphia 44, Pa.

More than Half a Century of Service to the Medical Profession

Chemically Standardized Veratrum Viride Is Effective in Hypertension

Much has been written pro and con about the value of veratrum viride in hypertension. For many years the drug has been in disrepute because of the fact that the preparations available on the market have been prepared by "hit or miss" methods.

Chemical standardization of veratrum viride, however, has provided in this drug a highly effective agent for the treatment of hypertensive patients.

Sollmann[1] states that veratrum is probably the most active and reliable cardiac depressant and that its use serves to slow and soften the pulse and lower the blood pressure.

Willson & Smith[2] state that veratrum viride possesses a vasodilating effect and because of this, it was demonstrated by Hite,[3] and Freis and Stanton,[4] that the drug lowered pressure in hypertension and gave symptomatic relief. Recent research tends to show that the decrease in blood pressure results more from peripheral vasodilation than from depression of cardiac output.

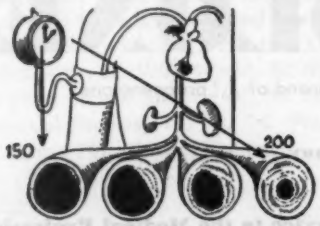
Uniformity of Action

When the veratrum alkaloids are chemically standardized, a uniform result can be expected. Their action usually causes a reflex fall in blood pressure and heart rate which originates in the afferent vagus nerve endings in the myocardium of the left ventricle and in the lungs. Although these factors ordinarily result with each heart beat, the veratrum alkaloids cause them to act continuously over prolonged periods of time. Reports have shown that 80 to 90 per cent of hypertensive patients respond to therapy when chemically standardized veratrum viride is used.

Cardio-Vascular Symptoms Cleared

In addition to the lowered pressure, objective signs of improvement may be observed, such as the clearing of retinal hemorrhages, diminution in cardiac size and reversal of left ventricular strain patterns in electrocardiograms.

Accompanying symptoms of the cardiac-hypertension syndrome, such as exertional dyspnea, tachycardia, nervous irritability, headache, are relieved. Yet, while the results of veratrum viride medication are prolonged, the drug may not afford quick relief.



Role of the Nitrites

For prompt and effective fall in blood pressure, nitroglycerin, which acts in one to two minutes, is the drug of choice. It acts rapidly and, because of its powerful vasodilatory action, gives the patient almost immediate relief. The action of nitroglycerin, however, is fleeting and to sustain lowered pressure between the action of nitroglycerin and veratrum viride, an intermediate is necessary.

To this end, sodium nitrite is used. This drug is also a vasodilator and affords sustaining relief until the long range action of chemically standardized veratrum viride becomes effective.

Importance of Sedation

Nearly all cases of hypertension require sedation for allaying periods of anxiety and affording the patient a good night's rest. Mild sedation is often useful, especially in cases associated with chronic coronary insufficiency.[5] It is well known that excitement may induce anginal attacks and in such cases, phenobarbital, because of its prolonged action, should be used.

All of these drugs, chemically standardized veratrum viride, nitroglycerin, sodium nitrite, and phenobarbital are to be found in Capsules RAY-TROTE IMPROVED, prepared by the Raymer Pharmacal Company of Philadelphia, Pa. Each capsule contains

Phenobarbital	15 mg.
Sodium Nitrite	30 mg.
Nitroglycerin	0.25 mg.

With the equivalent of Veratrum Viride Tincture 4 minims (containing 0.1% alkaloids)

RAY-TROTE IMPROVED is effective in dosages of one capsule every three hours. It is contraindicated when renal insufficiency is present, or if pulse becomes abnormally slow following treatment.

For the 30% of hypertensive patients with capillary fault, the above formula, with 20 mg. of Rutin added, is available in RAY-TROTE with Rutin.

Bibliography

1. Sollmann: A Manual of Pharmacology, W. B. Saunders Co. (1942).
2. Willson & Smith: J. Pharmacol., 79:208 (1943).
3. Hite: Ill. M. J., 90:336 (1946).
4. Freis & Stanton: Am. Heart J., 36:723 (1948).
5. Falk: South. M. J., 40:501 (1947).

Send for a liberal clinical supply of RAY-TROTE IMPROVED Capsules and descriptive literature today to Raymer Pharmacal Company, N.E. Cor. Jasper and Willard Streets, Philadelphia 34, Pa.

announcing Feojectin

for use when oral iron fails

"Many of the clinical results are as dramatic as the response of pernicious anemia in relapse to full doses of parenteral liver."
(Slack and Wilkinson, Brit. M.J., April 17, 1948)

Feojectin is a stable solution of saccharated iron oxide for *intravenous* injection. It is particularly indicated for those cases of iron-deficiency anemia in which oral medication (1) is relatively ineffective, (2) is not well tolerated, or (3) produces results too slowly.

Feojectin is supplied in boxes of six 5 cc. ampuls. (Each ampul contains the equivalent of 100 mg. of elemental iron.)

Smith, Kline & French Laboratories, Philadelphia

Feojectin

a completely new form of iron therapy

NEW!

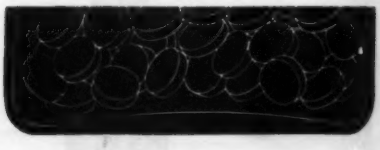
Carmethose–Trasentine

Doubly effective in relieving gastric discomfort...

Carmethose-Trasentine is a logical combination of a new *antacid* and an effective *antispasmodic* to control gastric discomfort.

Controls hyperacidity... This combination lowers gastric acidity and forms a protective coating which has been observed in the stomach for as long as three hours.

Controls spasm... Carmethose-Trasentine relieves gastric pain also by relaxing smooth muscle spasm. The anesthetic effect of Trasentine further controls gastric irritability. Carmethose-Trasentine is non-constipating, palatable and eliminates acid-rebound.



Issued: Carmethose-Trasentine Tablets; sodium carboxymethylcellulose, 225 mg.; magnesium oxide, 75 mg.; Trasentine, 25 mg. Bottles of 100.
Carmethose without Trasentine is also available for use in cases where the antispasmodic component is considered unnecessary. Available as Tablets, each containing sodium carboxymethylcellulose 225 mg., with magnesium oxide 75 mg., and as Liquid, a 5% solution of carboxymethylcellulose.

CARMETHOSE T.M. (brand of carboxymethylcellulose)
TRASENTINE ® (brand of adiphenine)

Ciba *Pharmaceutical Products, Inc.,*
Summit, N. J.

2-1000M

In Hypochromic Anemia

OVOFERRIN offers the strength of iron — the touch of velvet

OVOFERRIN possesses *all* the qualities so necessary to effective iron therapy . . . without the untoward effects characteristic of iron in noncolloidal, ionized form.

OVOFERRIN has palatability, easy assimilation and maximum tolerance, which makes possible effective dosage levels for all needs, in both therapy and maintenance.

For better results for more patients prescribe

OVOFERRIN the build-up without a let-down

℞ **MAINTENANCE DOSAGE**

FOR ADULTS AND CHILDREN: One teaspoonful 2 or 3 times a day in water or milk.

℞ **THERAPEUTIC DOSAGE**

ADULTS: One tablespoonful 3 or 4 times daily in water or milk. CHILDREN: One to 2 teaspoonfuls 4 times daily in water or milk.

Professional sample on request

Made only by the

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when mental depression and nutritional inadequacy manifest themselves as

apathy

lethargy

physical debility

℞ 'Dexedrine' plus essential B vitamins

Theptine

a light and palatable antidepressant and restorative elixir

Each 5 cc. (1 teaspoonful) contains:
'Dexedrine'* Sulfate, 2.5 mg.; thiamine hydrochloride, 5.0 mg.; riboflavin, 0.45 mg.; niacin, 6.7 mg.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

Easter Island Figurine; Photo courtesy University of Pennsylvania Museum

Memo from the Publisher

• Panorama, according to Noah Webster, means "a picture exhibited a part at a time, by being unrolled before the spectator." A reader of MEDICAL ECONOMICS once put it somewhat differently. "Reading your Panorama department," he wrote, "is like reading the month's most interesting news by flashes of lightning."

On display in this showcase are oddments culled from some 300 different sources. When put through our editorial wringer, they come out this way:

"Physicians in Normandy, France recently staged a one-day strike to protest 'exorbitant taxation' . . . A Des Moines physician has organized his ulcer patients into group called 'Ulcers Anonymous' . . . One-third of 52,000 V.A. mental patients haven't been visited by family or friends in over a year . . . Doctors' share of the medical care dollar has dwindled in last twenty years from 32 cents to 25 cents . . . Medical students, who once sold blood to get pocket money, now pick up occasional fees as donors in artificial insemination, reports Detroit Medical News."

To turn up such tidbits, M.E. staffers each month comb through 135 periodicals (medical, business, general) and 100 daily newspapers. They sift reports from field men,

letters from doctors, clippings from free lances. Raw material may stem from such diverse sources as the CIO News, the Wall Street Journal, Public Health Reports, the Pottawatomie County Medical Society Bulletin, and the Congressional Record.

All items of possible interest to private physicians (about 500 clippings a month) are dumped on the desk of our Panorama editor. He screens out the choicest morsels —a striking statistic, a vivid quote, a two-sentence narrative, a straw in the wind—and turns them over to a staff writer. Each item is then checked and worked over until it emerges in capsule form. (News stories that *can't* be capsuled are booked for our Newsvane department, in the back of the book.)

Most capsules are easy to swallow—which probably accounts for the high readership Panorama gets. But the unique flavor of some of its news nuggets also helps. For this we have our many correspondents—both volunteer and professional—to thank.

After all, where else would you find out that a Long Island physician had extracted a lighted cigar from an accident victim's throat? Or that Mrs. Kate Newman of South Milford, Ind., is the daughter, wife, widow, sister, grandmother, niece, first cousin, and second cousin of doctors? Or that the International Academy of Proctology is now located in Flushing, N.Y.?

—LANSING CHAPMAN

Psychoneurotic Women of Genius

Isadora Duncan, renowned American dancer, was admired throughout the world for her creative ideas and graceful artistry, but estranged her native public through her psychoneurotic eccentricities.

The majority of psychoneurotics have no serious mental illness, but display merely an emotional imbalance which often can be greatly improved by appropriate psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is especially useful when tranquillity with minimal hypnotic action is desired. Sedative dose: Adults, from 32 mg. to 0.1 Gm. (½ to 1½ grains) three or four times daily. Children, from 16 to 32 mg. (¼ to ½ grain) three or four times daily. Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

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TASTELESS SEDATIVE AND ANTIEPILEPTIC • LITTLE OR NO DROWSINESS

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regular and elastic
BAND-AID
ADHESIVE BANDAGE
STERILE
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PLAIN
GAUZE PAD
made only by
XUM

Johnson
ND-AID
VE BANDAGES
ADHESIVE BANDAGES
AND-AID
ADHESIVE BANDAGES

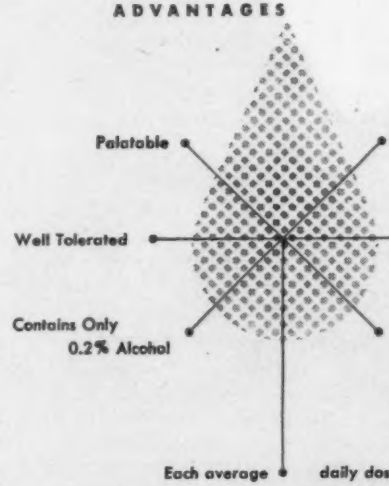
XUM

'Procebrin'

(Pan-Vitamins, Pediatric, Lilly)

A highly concentrated vitamin preparation especially suitable for routine prophylaxis or therapeutic administration to premature babies, infants, and growing children.

ADVANTAGES



Supplied in 15-cc. bottles.

Included is an easily read dropper which is calibrated to provide 0.15 and 0.30-cc. doses.

Each average daily dose of 0.3 cc. contains:

Thiamin Chloride (Vitamin B_1)	1 mg.
Riboflavin (Vitamin B_2)	0.5 mg.
Pyridoxine (Vitamin B_6) Hydrochloride	0.5 mg.
Pantothenic Acid (as Sodium Pantothenate)	1.5 mg.
Nicotinamide	8 mg.
Ascorbic Acid (Vitamin C)	60 mg.
Vitamin A	3,000 U.S.P. or International units
Vitamin D	800 U.S.P. or International units

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ELI LILLY AND COMPANY

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Panorama

More than 18,000 U.S. companies now provide sickness insurance for more than 2 million employes, says AMA Council on Medical Service . . . Send protests against nationalized medicine to your Congressmen, not to President Truman, advises Indiana State Medical Association; Truman turns them over to Oscar R. Ewing, who sends out disarming, honey-worded replies.

Panama Canal advertising for physicians to do hospital work in almost full range of specialties, now that Army is withdrawing medical officers. Salaries range from $6,750 to $9,500, plus free transportation, says Chief of Office, Panama Canal, Washington 25, D.C. . . . Blue Cross currently spending 89 cents of each income dollar on benefits, eight cents for administration, three cents for reserves . . . Brief refresher courses for G.P.'s offered by anesthesiologists in many states. For information, write Suite 923, 188 West Randolph St., Chicago 1, Ill. . . . Foreigners made up 14 per cent of "temporary residents" who got free medical care in London under National Health scheme during a recent quarter.

Quarreling members of New York County Medical Society, long at odds over approving AMA's $25 dues, decided to put issue to secret referendum . . . Expose of U.S. socialism, "The Road Ahead" by John T. Flynn, being distributed among employes of such organizations as National Steel and Armstrong Cork. Paper-bound copies cost 50 cents each. Volume hailed by Pennsylvania Medical Society: " 'Uncle Tom's Cabin' did more good than all the Abolitionist literature produced prior to 1853. 'The Road Ahead' will do more good, if properly distributed, than all the anti-socialist literature distrib-

in rheumatic affections...

how can Pabalate provide better salicylate therapy than pure salicylate itself?

THE SUCCESS of salicylate therapy in rheumatic affection has been shown by authoritative reports[3,6] to depend largely o the maintenance of really adequate blood levels . . . frequently a difficult achievement under usual salicylate administration. Pabalate supplies not only salicylate, but also a "booster" in the form of the antirheumatic para-aminobenzoic acid,[7] which acts to *increase* blood levels of salicylate.[1,2,4,5] In turn, the salicylate increases the blood concentration of the para-aminobenzoic acid.[2] Enteric coating helps Pabalate prev gastric irritation, insures optimal toleration.

Successful clinical results, contingent on adequate blood level can thus be achieved better, more dependably, with Pabalate the "new word for salicylate" in therapy of rheumatic affection

A. H. ROBINS COMPANY, INC. • RICHMOND 20, VA.
Ethical Pharmaceuticals of Merit since 1878

higher **salicylate blood levels for** better **antirheumatic ther**

INDICATIONS: Pabalate Tablets—for adult patients with rheumatoid arthritis, acute rheumatic fever, fibrositis, gout and osteo-arthritis. *Liquid Pabalate*—for treatment of acute rheumatic fever or other rheumatic diseases in children and as a replacement for tablet salicylate medication; or for adults who prefer a liquid dosage form.

DOSAGE: Average adult dose: two tablets or teaspoonfuls, three or four times daily. Dosage should be adjusted upward if necessary. For children, dosage is proportional to age and severity of condition.

FORMULA: Each enteric-coated tablet or each teaspoonful contains Sodium Salicylate, U.S.P. (5 grs.) 0.3 Gm.; Para-aminobenzoic Acid (as the sodium salt) (5 grs.) 0.3 Gm.

SUPPLIED: Pabalate Tablets in bottles of 100 and 500. Liquid Pabalate in bottles of 1 pint.

REFERENCES:

1. Bilde, M.: Union Med. Canada, 77:392, 1948
2. Dry, T. J. et al.: Proc. Staff Meetings Mayo Clinic, 21:497, 1946
3. Editorial: J.A.M.A., 138:367, 1948
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6. Reid, J.: Quart. J. Med., 17:139, 1948
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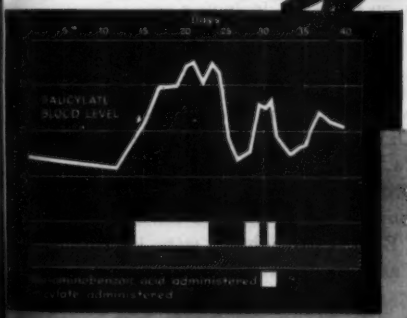
Para-aminobenzoic acid increases blood levels of concurrently administered salicylate.[3]



For treatment of rheumatic affections

℞ *Pabalate*®

XUM

uted up to 1950" . . . Biggest Blue Shield plan, United Medical Service (N.Y.), reports 1,547,657 members, 17,838 participating physicians, $6,781,596 paid out in benefits in 1949.

For adequate infant and maternal care, the states need $50 million worth of Federal aid annually, says Dr. Leona Baumgartner of U.S. Children's Bureau; $18 million a year granted by Congress, she claims, is not enough . . . Charles S. Blondy, Michigan State Senator is aiming for investigation of AMA "monopoly," which has "raised training standards so high that qualified men are barred from field" . . . In a letter to The Washington Star, Howard University medical students voice resentment that no Howard professor was invited to speak at AMA midwinter clinical session . . . Dr. Elmer Belt of California Board of Health reports smog in Los Angeles so bad that patient with glass eye, arriving from East, had to buy new, bloodshot eye to match his good one.

Medical artists and photographers, sometimes hard to find in a hurry, now being listed by Academy-International of Medicine, 214 W. 6th St., Topeka, Kans. . . . County medical societies now have about 139,000 members all told, estimates AMA. Those with less than 100 members make up 88 per cent of the 1,930 societies; 100-199 members, 6 per cent; 200-299, 2 per cent; 300 and up, 4 per cent . . . Cost of Truman welfare state would increase average family's estimated tax load, now $1,128 a year, from 33 to 75 per cent, says Carrol M. Shanks, president of Prudential Insurance Co. . . . Republican Congressmen have set up committee to issue national publicity on cost of every item in Truman program, including compulsory health insurance.

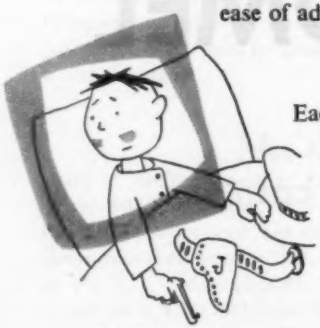
Man who "wore out five horses" in 66 years of medical practice, Dr. Dave S. Stewart, died recently at age 102, in Creston, W.Va. . . . English pinko, Dr. Arna E. Rides, has renounced her citizenship and gone to Communist Czechoslovakia because Britons are "being led into subservience of U.S." . . . Massachusetts Blue Cross fighting state bill that would tax it $100,000 a year as "cooperative insurance venture."

In Childhood Fevers—

The youngster with an acute febrile condition will be more cooperative if pleasant-tasting Aspergum is selected as the antifebrile agent.

Quickly soluble in the saliva and gastric juice, the acetylsalicylic acid in Aspergum reaches the blood stream rapidly.

Whenever aspirin is indicated, depend on Aspergum for ease of administration. Ethically promoted—not advertised to the public.



Each pleasantly flavored Aspergum tablet contains 3½ grains of acetylsalicylic acid—a dosage form uniquely fitted to childhood requirements.

aspergum

NEW *precision*

NEW *serviceability*

NEW *visibility*

NEW *sensitivity*

NEW *convenience*

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THE B-D YALE ANEROID MANOMETER

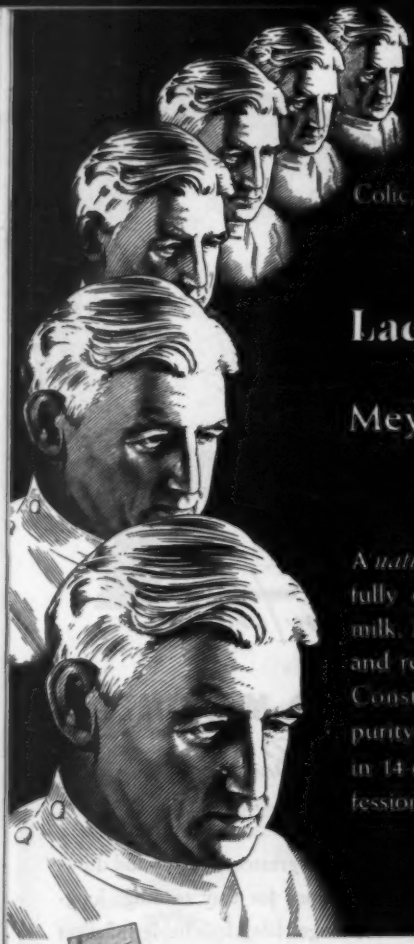
Jeweled Bearing

We've borrowed from the watchmaker's craft to give you a Jeweled·Bearing sphygmomanometer for greater accuracy and durability. Uniformly-spaced scale graduations for easy reading; long-travel beryllium copper bellows for longer life; detachable inflation system with the new B-D SECURITY CUFF (hook-type) for greater convenience and flexibility. *Guaranteed indefinitely* against all defects in material or workmanship.

See it at your dealer's . . . look for the red dot on its face . . . it identifies the Jeweled·Bearing B-D YALE ANEROID MANOMETER.

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.



Formula changed?
Colic, vomiting, diarrhea unrelieved?
Consider the presence of

Cow's Milk Lactalbumin Allergy

Prescribe

Meyenberg® Evaporated Goat Milk

A *natural* milk, nutritionally and flavorfully equivalent to evaporated cow's milk. May be substituted in formulae and recipes without change in values. Constant control assures uniformity, purity. Available at most drug stores in 14 oz. cans. Advertised to the profession only.

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Los Angeles 64, California • Since 1934

BY THE MAKERS OF *Hi-Pro*®—HIGH PROTEIN, LOW-FAT POWDERED COW'S

Profexray SETS THE PACE AGAIN!

100 MA-100 KV TWO-TUBE TILT TABLE

COMBINATION RADIOGRAPHIC AND FLUOROSCOPIC UNIT

$2895

F. O. B. CHICAGO

Includes (1) All-automatic push-button control (2) Electronic timer (3) Double focus 100 MA tube head (4) Separate fluoroscopic tube head (5) 12 x 16 Patterson B-2 screen (6) L-F Bucky.

Never before...at even roughly comparable price... could the doctor obtain such full use of all x-ray modalities, such effortless, time-saving convenience, such excellent diagnostic quality. But that is by no means all! No other unit *at any price* offers the features of the PROFEXRAY All-automatic Push-button Control. Triple-interlocking control of time-KV-MA factors now permits *full use of 100 MA techniques* with a unit rated at 100 MA. The control makes overloading of tubes *absolutely impossible*...and introduces new safety factors for both patient and operator. Selection of the proper technique is simple even for unskilled technicians. The coupon brings complete information.

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PROFEXRAY occupies fully 10 inches less space than other tilt-table units...fits where bulkier units won't go. Extension leaf gives full length efficiency. May be used as standard or auxiliary examining table with optional pad and stirrups.

Profexray

...pace-making design

...at down-to-earth cost

PROFESSIONAL EQUIPMENT CO.
615 S. Peoria St., Chicago 7, Ill.

Gentlemen:

Please send complete information on the Profexray 100-100 Tilt Table Unit. No obligation.

DR. _____

ADDRESS _____

Rapid, sustained relief follows topical application of CALADRYL—the soothing new calamine-type antipruritic lotion containing BENADRYL®

CALADRYL

TRADE MARK

effective: CALADRYL effectively relieves sunburn and itching. Benadryl hydrochloride (1%), calamine, camphor, glycerin and other ingredients are blended in a soothing lotion for effective antihistaminic and antipruritic action.

pleasant: CALADRYL is pleasant to use. Faintly perfumed, its light flesh color is cosmetically inconspicuous. It does not rub off but washes off easily.

versatile: CALADRYL has many uses. It soothes sunburn's itching and burning. Prickly heat, diaper and cosmetic rash are readily relieved as is the itch associated with hives, insect bites, poison oak, poison ivy, measles, chicken pox, contact dermatitis, and minor skin affections.

PARKE, DAVIS & COMPANY

MEDICAMENTA VERA

Speaking Frankly

Slump

The January article "Your Practice and the Slump" presented most of the more important arguments for a national—but not necessarily government-controlled—health insurance program. The article points out that even a minor economic disturbance is a threat to the financial security of practicing physicians. Also, when money is a factor people delay seeing the doctor until further procrastination is dangerous.

When individuals are covered by medical care insurance they need not deny themselves the benefits of early diagnosis and treatment. Furthermore, physicians are guaranteed their fees.

Leonard J. Goldwater, M.D.
New York, N.Y.

AMA, Jr.

Congratulations on your timely article about the Association of Internes and Medical Students! It corroborates the opinion many of us have held about the organization. And it may open the eyes of some of its own members who are not aware of its true purpose.

A group of students here at Illinois provided some of the impetus for the resolution that the House of Delegates passed in December, initiating the formation of a "Junior AMA." We are now launching a temporary organization among the five medical schools in Chicago and have held two meetings so far. We are hopeful that our plans, when completed, will offer the precipitation point for a national organization, affiliated with the AMA. We have, in fact, been working unofficially with the AMA in this program.

Anyone at any other medical school in the country who would be interested in an organization of this type is invited to correspond with our group. I am already in contact with the University of Virginia group you mentioned in your article.

Harry W. Sandberg, Med. 2
University of Illinois
Chicago

Letters for Reader Sandberg, addressed to MEDICAL ECONOMICS, *will be forwarded promptly.*

Socialism

Your articles on socialism are most timely. They should be followed by continued hammering so that doctors will realize what must be done

and lose no time in doing it. I am reading John T. Flynn's "The Road Ahead." Every doctor—for that matter, every American—should read it. As president of my local county medical society for 1950, I hope I may be able to contribute something which will help save our country from socialism.

M.D., Mississippi

The discussions of socialism and socialized medicine are like water off a duck's back as far as the average voter is concerned. He's not concerned with the quality of medical care, as is shown by the millions who patronize quacks. Better prove to him how compulsory health insurance will cost more than present voluntary plans. The pocketbook is the main appeal.

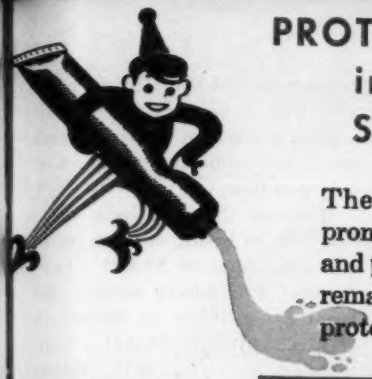
M.D., California

The time to prepare for the preservation of American institutions is at the coming November election. If the medical profession will contribute in time and funds we may stop socialized medicine; otherwise it will be difficult to avoid the disastrous results that have come upon our friends across the water.

M.D., Maryland

Miners

When the United Mine Workers' welfare plan, described in your March issue, was inaugurated in this state, doctors were told that the average miner had an income of about $2,400 a year and that a modest fee was all that could prop-



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The effective formula of Cremacal promptly relieves the pruritus, burning and pain of dermatologic conditions, and remains on the surface to continue its protective relief over a prolonged period.

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Washes Off with Plain Water

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Formula:

Calamine	10%
Glycerine	5%
Benzocaine	1%
Phenol	0.5%
Menthol	0.25%
Special Water-Miscible Base	q.s.

Flesh-tinted with ivert coloring. Supplied in 2-oz. tubes.

NUMOTIZINE, Inc.

erly be charged him. This is probably true in sections where shaft mining is common or where small mines are numerous and work is only part-time.

However, there has been objection here to basing our fees on an average income of $2,400 a year. In many strip-mining sections, the average miner has an income of at least $4,000 to $6,000 a year.

M.D., Illinois

Bank

The Alameda County Medical Association blood bank, described in your February issue, is an outstanding example of cooperative effort by physicians and the public to maintain a private blood bank. Safe blood is being supplied to the patient without cost because of the replacement feature. The Committee on Blood Banks of the American Medical Association urges physicians interested in a private community blood bank to investigate the operation of the Alameda bank.

L. W. Larson, M.D., Chmn.
AMA Committee on Blood Banks
Bismarck, N.D.

Fees

As general practitioners know only too well, it is the extra medical services that work hardship on many patients, not the everyday office or house-call fee. By "extra medical services" I mean such things as X-rays, surgical fees, and hospital expenses.

In my opinion, the AMA should study these charges and bring its

influence to bear in having them scaled down. My radiological and surgical friends will no doubt shout to the roof tops; but I submit that the average layman will be receptive to socialized medicine propaganda as long as he is charged eleven or twelve dollars for a chest X-ray that seldom costs more than 35 cents.

M.D., Pennsylvania

The doctor in America sets himself too high in the scale of human endeavor. If you are going to avoid a socialist state in medicine, fees must be reduced. A few suggestions:

Childbirth, normal	$100
Childbirth, abnormal (and no chiseling)	150
Caesarean section	150-250
Appendectomy	150-250

Eric R. Wilson, M.D.
Van Nuys, Calif.

ACES

Americans for the Competitive Enterprise System is vulnerable when it states, as you reported in January, that contributions to its fund will be tax-deductible. As any tax lawyer knows, such contributions are not deductible for income tax purposes.

Mac F. Cahal, Exec. Secy.
Am. Acad. of General Practice
Kansas City, Mo.

Contributions are *deductible, says ACES, because "We do not intend to get into politics or to lobby or otherwise attempt to influ-*

Widen the scope of routine office examinations

CLINITEST

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for detection of occult blood

Occult blood in feces, sputum or urine is often the earliest evidence of pathologic processes otherwise unsuspected. Determination of blood (present as 1 or more parts in 20,000) becomes a practical part of office routine with *Hematest* (Brand) Reagent Tablets—accurate, quick, and convenient. Bottles of 60 and 500.

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ence legislation. We are not a political action group. We intend merely to educate people in the advantages of our American competitive system as opposed to communism, fascism, or socialism."

Exams

I read "The Non-Certified Specialist Speaks" with interest because—with medical school twenty years behind me—I recently took the board examinations in internal medicine.

In the last two decades I've had a busy practice and for five years have been in charge of a personnel clinic for 3,000 employes. None of these activities is conducive to relearning the basic sciences. However, with the aid of a month's vigorous study, I passed the written exams.

What will happen at the orals is any man's guess. But, tough as the writtens are, the doctor-author of your article ought to try them. He might surprise himself.

M.D., New York

Names

In January "Speaking Frankly" I note a reference to a Dr. Ernest Klein who was dismissed from Bellevue's University Hospital because of a controversial research report. There seem to be several physicians of this name. I wish it known that I am not the Dr. Ernest Klein referred to.

Ernest S. Klein, M.D., Act. Supt.
Kankakee State Hospital
Kankakee, Ill.

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PROGYNON-B is available in ampuls of 0.166, 0.333, 1.0 or 1.666 mg. (1000, 2000, 6000 or 10,000 R.U.), boxes of 3, 6, 50 and 100 ampuls; and in 10 cc. multiple dose vials containing 0.166, 0.333, 1.0 or 3.333 mg. (1000, 2000, 6000 or 20,000 R.U.) per cc., boxes of 1 and 6 vials.

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FURACIN ANHYDROUS EAR SOLUTION

In the treatment of bacterial OTITIS media et externa, over 200 reported cases attest that Furacin is a highly effective adjunct.* Many cases of chronic otitis responded which had proven refractory to other medicaments. Among the pathogens isolated were Escherichia coli, Proteus vulgaris, Pseudomonas species, staphylococci, streptococci and diphtheroids. Furacin Anhydrous Ear Solution contains Furacin® 0.2 per cent, brand of nitrofurazone N.N.R. in an anhydrous, hygroscopic, water-soluble liquid: polyethylene glycol. It is indicated for topical treatment of bacterial otitis media et externa.

Literature on request.

*Anderson, J. and Steele, C.: *Use of Nitrofuran Therapy in External Otitis*, Laryngoscope 58:1279, 1948 • Douglass C.: *The Use of Furacin in the Treatment of Aural Infections*, Laryngoscope 58:1274, 1948 • Reardon, H.: *Unpublished results.*

OF THE FURACIN FAMILY...

For the treatment of bacterial cervicitis and vaginitis.
Furacin, the powerful antibacterial agent, is now available in vaginal suppository form. It has produced excellent results in treating cervicitis of bacterial origin, especially in clearing cervical infections *prior* to electro-surgery and hysterectomy and *postoperatively* to minimize infection, slough, discharge and malodor.

The wide antibacterial spectrum of Furacin, encompassing the majority of bacteria of surface infections, is complemented by the water-dispersible, self-emulsifying base which melts at body temperature and clings tenaciously to the vaginal mucosa. Furacin is not effective against trichomonads or fungi.

The NITROFURANS
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a unique class of antibacterials

Furacin Vaginal Suppositories contain Furacin® 0.2 per cent, brand of nitrofurazone N.N.R. in glyceryl laurate and synthetic wax. They are hermetically sealed in foil. *Literature on request.*

EATON LABORATORIES, INC., NORWICH, N. Y.

emotional equilibrium for the geriatric patient

Thousands of doctors know that BENZEBAR* allays the mental depressi apprehension and nervousness so frequently found in the elderly patie 'Benzebar' is S.K.F.'s logical combination of Benzedrine* Sulfate (race amphetamine sulfate, S.K.F.) and phenobarbital. It provides the uniq improvement of mood of 'Benzedrine' Sulfate and the calming, soothi influence of phenobarbital. These two established agents work togeth to restore the elderly person's zest for life and living, to quiet his nervo ness and, at the same time, to keep him from overdoing.

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*"Benzedrine' and 'Benzebar' T.M. Reg. U.S. Pat. Off.

Sidelights

Everybody's Doing It

Medical grievance committees have become a *sine qua non* even among the profession in Pakistan. At least that's the report of our Asiatic correspondent, Khalid Askry of Karachi. He quotes the Hon. Secretary of the Pakistan Medical Association as having announced that "Acts of negligence (and, presumably, overcharging) by some doctors have been reported in various newspapers. These acts are being investigated. I would request members of the public to bring all such matters to the notice of the president of our association."

Socialist Rx

Well, it's finally happened. Confronted with the upswept cost of the National Health Service, Britain's Health Ministry has put out a new edict about prescribing habits. As predicted earlier, it takes one more bite out of the doctors' well-nibbled professional freedom.

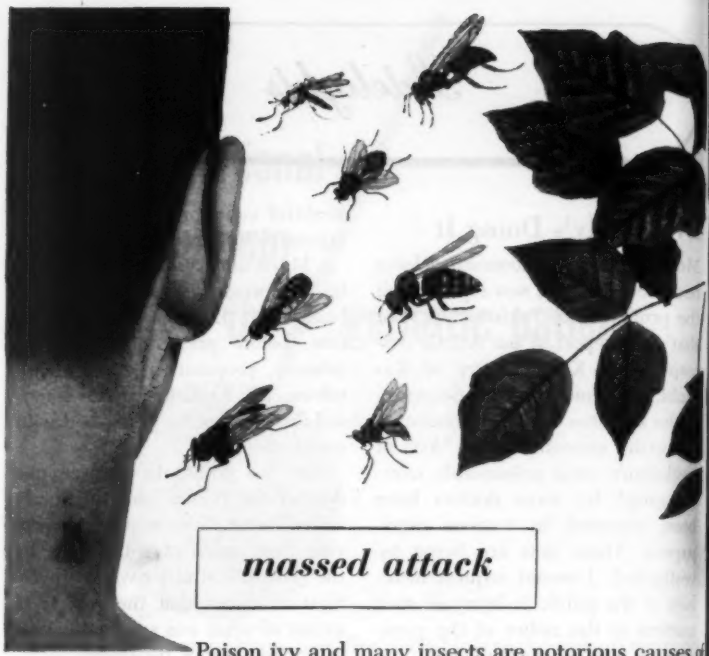
The new decree is signed by Sir Wilson Jameson, chief medical officer of the NHS. "Recent investigations," it says, "have shown that large sums of money are being spent on drugs and medicines of doubtful value or on unnecessarily expensive brands of standard drugs . . . Much unnecessary cost [is] due to the prescribing of proprietary brands . . . Doctors should, therefore, before prescribing any proprietary preparations, ask themselves: 'Am I satisfied that a standard drug cannot be prescribed with equal effect?' "

Get the point? In case anyone doesn't, Sir Wilson adds this thinly veiled threat: "The regulations provide that action may be taken by the [Health] Minister where 'investigation shows that the cost is in excess of what was reasonably necessary for proper treatment.' "

Everyone wants Government to economize. Not everyone wants Government to be the arbiter of what is "necessary for proper treatment." Yet the sad truth about socialized medicine, as British doctors are discovering, is that you can't have the first thing without the second.

Coming Attractions

For those who can't attend next month's San Francisco session of the AMA, our Department of Fearless Forecasting has it all doped out. Here's an uncensored report on



massed attack

Poison ivy and many insects are notorious causes of severe pruritus. Prompt and safe control of the itching is a prime therapeutic need, for the patient's scratching or self-medication can lead to serious sequelae.

Calmitol Ointment gives relief directly upon application. It may be used liberally and repeatedly without the risk of exacerbation, for Calmitol Ointment is free from dangerous drugs such as phenol (as in calamine with phenol), cocaine and cocaine derivatives.

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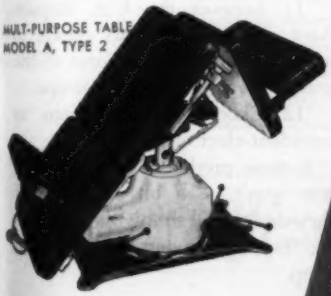
WHATEVER the problem, you can always examine patients at the height most convenient for you with a Ritter Multi-Purpose Table. This motor-driven table gives rapid, smooth adjustment to any required height by slight toe pressure on the foot pedal . . . your assurance of always working at *your comfort level.*

The Model A, Type 1, shown above, adjusts to any position from full horizontal to chair. Rotates 180° with range of elevations, 27″ to 45″ or 23″ to 41″, from table top to floor.

The Model A, Type 2 Multi-Purpose Table, shown at left, has the same features as the Type 1, plus a special adjustable knee rest for proctological work. Extreme tilt 55°. Elevation range 31″ to 49″, from table top to floor.

See your surgical dealer today for a demonstration of these Ritter Multi-Purpose Tables.



MULT-PURPOSE TABLE MODEL A, TYPE 2

the key actions medicine's policy-makers will take:

"Gemini being in the ascendant, the AMA will

"1. Elaborate its twelve-point program so as to convince more people that the association has a constructive approach.

"2. Give the green light to a national advertising campaign.

"3. Spell out new policies on lay-sponsored health plans, on the hospital practice of medicine.

"4. Try for some liberalization in the licensing of DP physicians.

"5. Urge local medical societies to crack down on doctors who charge excessive fees.

"6. Set up a Junior AMA for internes and medical students.

"7. Encourage home-town doctors to form political action committees, independent of the AMA.

"8. Emphasize that the future of private medicine hinges on this year's Congressional elections.

"9. Announce what the AMA is *for* in the realm of health legislation.

"10. Iron out the kinks that have been slowing up the collection of AMA dues.

"11. Support the U.S. Department of Defense in its efforts to squeeze more efficiency out of the armed forces' medical set-ups.

"12. Choose a Californian as president-elect of the AMA."

If these predictions pan out, our seer won't be a bit surprised. If they don't, he'll simply have to take the rap for having crystal-balled it up.

Terramycin

Effective against a wide spectrum of bacterial, viral, rickettsial agents, and certain important protozoan organisms.

Terramycin

is available in 250 mg. capsules, 16 to the bottle. Dosage range—depending on the infection being treated—is from 2 to 3 grams daily in divided dosage.

indicated for: *acute pneumococcal infections, including lobar pneumonia, bacteremia, acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus and other Terramycin-sensitive organisms; brucellosis (abortus, melitensis, suis); hemophilus infections, including whooping cough (exclusive of meningitis); acute gonococcal infections; syphilis; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; herpes zoster; typhus (scrub, epidemic, murine); rickettsialpox; amebiasis (Endamoeba histolytica).*

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Oral Penicillin

FOR YOUR YOUNG PATIENTS

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Soltabs crystalline penicillin G potassium make for utmost simplicity and ease of therapy when penicillin is indicated. Containing neither binder nor excipient, they readily dissolve in water, milk, or infant formulas without appreciably changing the taste of the vehicle. Infants and children may thus be given their penicillin without the development of resistance to unpleasant taste or to the unpleasant experience of hypodermic injections.

Soltabs crystalline penicillin G potassium are supplied in two potencies—50,000 units and 100,000 units per tablet—in boxes of 24, each tablet sealed in foil.

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- **When vasodilation alone is indicated.** *Nitranitol.* (½ gr. mannitol hexanitrate.)
- **When sedation is desired.** *Nitranitol with Phenobarbital.* (½ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)
- **For extra protection against hazards of capillary fragility.** *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)
- **When the threat of cardiac failure exists.** *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ½ gr. Phenobarbital and 1½ gr. Theophylline.)

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A bactericidal SOAP

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In Office, Home, Operating Room and All Cleansing Procedures

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Gamophen contains hexachlorophene (2%),* the most effective, longest-acting skin antiseptic known. The soap base was specifically selected to provide optimum release of hexachlorophene's bactericidal properties, without irritating or drying the skin. Gamophen has been tested in 3½ years of laboratory and clinical evaluation.

Prolonged Antibacterial Effect

The hexachlorophene exerts a prolonged antibacterial effect against the resident flora of the skin, gram-positive and gram-negative organisms, pathogenic and non-pathogenic bacteria.

Several investigators have found that the standard scrub of 15 or 20 minutes may safely be reduced to from 3 to 5 minutes when Gamophen is used.

In a series of comparison tests it was found that the bactericidal action of Gamophen was 36% greater against mixed cultures of S. aureus, S. hemolyt

WHAT YOU GET IN GAMOPHEN

Bactericidal action. Sustained low count in regular use. Emollient effect —no irritation. Quick, rich lather in any water. An excellent deodorant. Economy—less than half the cost of liquid soap. Tremendous Time Saver—3-minute scrub is sufficient.

*"Hexachlorophene" has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association as the generic term for dihydroxyhexachlorodiphenyl methane.

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...NS AND HOSPITAL PERSONNEL

Emollient, Rich-Lathering, Fast-Acting Continuously-Effective, Economical

...us and E. coli, and 10% greater against Cl. welchii, than 3½% tincture iodine.

When used routinely for all cleansing occasions in hospital, office and home, Gamophen establishes a protective antibacterial film which exerts a continuous action. The marked degree of suppression achieved is maintained as long as this soap is used regularly and for several days after its use is stopped. The use of alcohol or other solvent rinses is contraindicated.

Bactericidal in 3-minute Scrub

Gamophen Soap is alkaline in solution, with a pH of 8.5 to 9. It is bactericidal in a 3-minute scrub in the concentrations used in normal scrub conditions. It quickly produces a thick, rich lather, even in hard and cold water. Every lot produced is tested for potency.

WHERE TO USE GAMOPHEN

In office and home. In the hospital wherever soap is used—by staff personnel or patients. For pre-operative antisepsis of skin. Industrial clinics and first aid stations.

In other tests, hexachlorophene in Gamophen was found to be more effective than it was in other vehicles, such as certain liquids having an acid pH, in which it is bacteriostatic but not bactericidal. Liquid solutions having an acid pH lower the effectiveness of hexachlorophene.

Gamophen is supplied in 4½-oz. bars for home and office; in 2-oz. bars for hospital personnel and patients' use.

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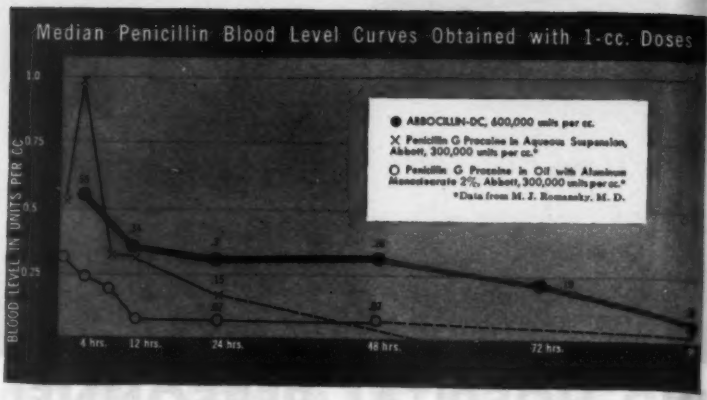

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True Repository Therapy

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*T.M. Reg. Becton Dickinson & Co.

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Editorial

Those Catastrophic Cases

● What shall we do to help people with extra-heavy medical costs?

The crux of the national health controversy is wrapped up in that question. Why? Let John Jones tell you:

"I'm not worried about normal medical bills. Blue Cross and Blue Shield protect me against most of those. But what about abnormal bills? Suppose someone in my family came down with cancer or t.b. The cost of it could wipe us out.

"I want protection against the big ones—and, so far, I can't buy it."

Every doctor has heard such sentiments. What's more, he knows of authentic cases that fan such fears. Like these:

¶ A midwestern housewife had a serious systemic infection. She was hospitalized for two months. By the time she was cured, her hospital bill stood at $4,500. (Her husband makes $50 a week.)

¶ A western woman was hospitalized for a premature delivery. She had lots of trouble but finally pulled through. Her hospital bill amounted to $1,500. (Her husband makes $60 a week, has three other children to support.)

¶ An eastern school teacher had a tough time with cancer. In one year, his hospital and medical bills totaled $2,300. Only 5 per cent of his outlays were covered by voluntary health insurance. (This man earns $2,800 a year.)

Such cases, of course, have a prodigious ripple effect. Friends and neighbors can easily picture themselves in the same plight. They spread the word—and the word is seldom favorable to private medicine.

What's the answer? What *shall* we do to help people with extra-heavy medical costs?

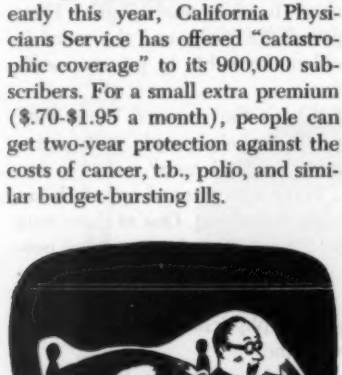
Three new lines of approach are being staked out. One of these *may* be the solution that gets the people's nod. But note this: Which one is picked makes a big difference to private physicians and to private medicine.

Douglas plan: Senator Paul H. Douglas (D., Ill.) urges tax-financed medical care for persons whose yearly health costs exceed $150 or 5 per cent of income, whichever is less. His plan would be limited to people earning less than $6,000 a year. A 1-per-cent payroll tax would pay for it. This scheme has the advantages of a quick solution, the drawbacks of

any Federally-run health plan.

Colorado plan: Doctors in this state seek a Federal income tax refund system. Under their plan, the Bureau of Internal Revenue would reimburse people for health costs that topped a specified percentage (perhaps 10 per cent) of their incomes. A 1-per-cent tax on wages, salaries, and personal incomes would finance the scheme. Though somewhat simpler than the Douglas proposal, this one has roughly the same advantages and drawbacks.

California plan: Physicians in this state aim to solve the problem through voluntary methods. Since early this year, California Physicians Service has offered "catastrophic coverage" to its 900,000 subscribers. For a small extra premium ($.70-$1.95 a month), people can get two-year protection against the costs of cancer, t.b., polio, and similar budget-bursting ills.



All of which brings into focus the No. 1 challenge facing our profession.

It is simply this: The problem of catastrophic illness costs *may* be solved through private, voluntary action—*if we work fast.*

This means the California plan must get an early test in other areas. The protection it offers must be broadened still more. The voluntary plans must be used to ward off compulsion. And we don't have much time.

Fortunately, we don't need much time. The number of families with crushing health costs is relatively small. If we insure them on a reasonably wide basis—say, through state-wide voluntary plans—we won't run much risk. If we try out the deductible idea (where the patient pays the first $50 or $100 of large medical bills), we'll be on still sounder footing.

But whatever we do, let no one minimize the stakes. Remember the story of John Gunther? He was a well-to-do journalist—until his son came down with a brain tumor. The cost of it wiped out the father's savings, threw him heavily in debt. A few months after his son died, John Gunther joined the Committee for the Nation's Health—to work for Federal medicine.

Before other people in the same fix do likewise, and before their friends follow suit, let's give catastrophic coverage the top priority it deserves.

—H. SHERIDAN BAKETEL, M.D.

AMA Readies Advertising Campaign

Million-dollar drive due to break this fall will use radio, newspapers, magazines

• Some morning next October, an ad in your home-town newspaper will probably catch your eye. It may start off something like this: "How YOU Can Take the Economic Shock Out of Illness. . ."

Along with 60 million other newspaper readers, you'll be witnessing the AMA's boldest bid for public support: a national advertising campaign in behalf of voluntary health insurance.

A year ago, medicine's leaders termed this sort of thing "expensive and politically unwise at this time." It's still expensive. In a few short weeks of press and radio advertising this fall, the AMA plans to spend a whopping $1 million. But with the November elections coming along, the time looks politically ripe.

That, at least, is the way AMA trustees see it. Here's how their plans shape up:

About $560,000 of the doctors' money will be ticketed for newspaper advertising. That sum will buy about two quarter-pages in every *bona fide* daily and weekly in the U.S. (11,000 papers, all told). Roughly two-thirds of the AMA copy—to be turned out by Whitaker & Baxter—will promote voluntary insurance. The other one-third of the text will hit at compulsory schemes.

The remaining $440,000 of the advertising fund will be earmarked for magazines and radio. About fifty national periodicals will be picked to carry the AMA message. Meanwhile, a network radio show will be launched to give medicine an aggregate of perhaps seven hours' air time to tell its story.

Those $25 Dues

These precedent-shattering decisions may not be formally announced until June. AMA trustees first want to see how dues collections are coming along. Barring unlooked-for impoverishment, however, the AMA will then flash the green light for its ad campaign.

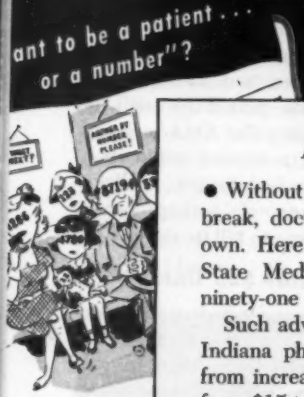
Is this a good thing? Some doctors don't think so. A number of them showed up at the February meeting of the AMA trustees to voice their objections. Here's what these people said about a national advertising campaign:

It's loaded with public relations

dangers. Commented a leading midwestern physician: "Some people might look on this campaign as a demonstration of wealth by the medical profession. This would align us, in the public mind, with many others whose recent campaigns have been failures."

It's loaded with political dangers. Said the secretary of a state medical association: "The proposed advertising campaign would simply give Oscar Ewing more ammunition. We've already had too much talk about 'slush funds.'"

It's not worth the expense. Said an executive of another medical society: "We don't have sufficient



Ad Campaign Gets Test Run

● Without waiting for the AMA advertising campaign to break, doctors in several states are moving ahead on their own. Here are some current ads sponsored by the Indiana State Medical Association. They've been published in all ninety-one of the state's daily papers and in all 270 weeklies.

Such advertising space, by the end of 1950, will have cost Indiana physicians nearly $50,000. The wherewithal comes from increased state medical society dues, which were hiked from $15 to $35 this year.

Is this campaign worth the cost? Officers of the Indiana State Medical Association think so. Said one last month:

"These ads give us a chance to jog the voters' memory just before the primary elections in May and just before the general elections in November. On each occasion we're running a series of four ads in every paper in the state. We're sticking to a few simple arguments against compulsory sickness insurance. It's our feeling that we can reach people this way whom we could not contact otherwise."

AMA ads may follow this same general pattern, but will lay much heavier stress on the merits of voluntary insurance.

funds to accomplish a first-class job in every newspaper. We need more grass-roots action, not more national advertising."

These views were challenged, however, by advocates of the ad campaign. Explained one:

"Public relations dangers? Sure, there are some. But our ads won't be splashy or negative. They'll be modest in size, positive in tone. Just because some other campaigns have failed, don't get the idea they all do. Look at the current ads of the A & P Company. They've brought the Justice Department before the bar of public opinion and have, for all practical purposes, won the A & P its case.

"Political dangers? Yes, there are some of these too. But we'll be in the position of having spent most of our money to boost existing health insurance plans. This is so obviously constructive an approach that our position should be almost unassailable.

"Not worth the money? Well, press and radio are our two greatest media for reaching the people. At a time when it's vital that medicine get its positive story across, it would be unthinkable to ignore these two. We don't need *just* a grass-roots campaign or *just* an advertising campaign. We need both."

Behind closed doors, AMA trustees threshed the matter out. Upshot: a unanimous vote for the fall ad campaign—association funds permitting.

In essence, of course, the AMA plan is not new. Indiana physicians, for example, are sponsoring their own statewide ad campaign this spring. California doctors have run a notably successful ad program ever since 1945.

In California, medical men have boosted voluntary plans via some

[*Continued on* 153]

Mr. Socialized Medicine is the "highest accolade" anyone could bestow on Oscar R. Ewing, Federal Security Administrator. At least that's the opinion of Jacob Potofsky, president of the Amalgamated Clothing Workers of America (CIO). He's shown here presenting Mr. Ewing with a $1,000 cash award—compliments of the Sidney Hillman Foundation—for being the year's "great public servant" and for seeking to "destroy the curse of charity" in medicine. Accepting the honor, Mr. Ewing responded with a few well-chosen jibes at "our good old country doctor" who "is not thinking about what he must do to cure his patient, but about how he must word his next letter to his Congressman."

Disability Checks From Uncle Sam?

Doctors describe hazards of Federal disability insurance before Senate committee

● "If a person can draw a nice pay check from the Federal Government each month for his disability, the stage is set for the making of a 14-carat invalid. And he'll resist any and all efforts toward rehabilitation."

Thus did Dr. James E. Paullin of Atlanta sum up a major argument in the case against Federal disability insurance. He was one of four witnesses to present medicine's view recently before the Senate Committee on Finance. The others were Drs. Bradford Murphey of Denver, Gunnar Gundersen of La Crosse, Wis., and R. L. Sensenich of South Bend.

The bone of contention was Section 107 of the Social Security Extension Bill,* which would give benefits to workers under 65 who became permanently and totally disabled. The testimony brought out three telling points against such insurance:

¶ It would put a cash premium on malingering, depriving patients of the will to recover.

¶ It would inevitably be extended, thus stimulating socialized medicine.

¶ It would strain the physician-patient relationship.

Point One: Federal disability insurance would foster malingering. The Senators were reminded that "neurotics bent on deceiving themselves" would use disability claims as a refuge from responsibility. What's more, warned the witnesses, little could be done to stop this abuse.

Said Dr. Paullin: "Once the unstable person decides that his claim is just, he develops symptoms as convincing as the real thing. Of course, if they were pathogenic, he'd be dead before he could describe them."

Federal Meal Ticket

When depression comes, it was pointed out, the neurotic takes to his bed before anyone can say, "Here's a job." Insurance companies were said to have learned this the hard way—especially between 1929 and 1933, when their disability claims increased from 50 to 100 per cent. "Under economic pressure," Dr. Gundersen noted, "dis-

*A full description of H.R. 6000 is given in "The Truth About Social Security," *Medical Economics*, March 1950.

ability insurance becomes unemployment compensation for the young and a pension for the old." But as Dr. Murphey said: Taking this easy way out is not without its hazard for the malingerer, since he may lose his will to recover. Settling a claim on a neurotic is sometimes, in fact, "a life sentence to invalidism."

Socialism Ahead

Point Two: Federal disability insurance would inevitably be extended. The witnesses needed no cork on a string to see which way the current was flowing. According to Dr. Gundersen, Section 107 would definitely set a course toward "a full-fledged system of compulsory sickness insurance." And it looked as if the Social Security Administrator would be captain on this cruise to the Sargasso Sea of socialism. His power under Section 107 was described by Dr. Murphey as "a menace to the private practice of medicine."

Point Three: Federal disability insurance would strain the physician-patient relationship. Dr. Sensenich pointed out the doctor's dilemma when called to settle a disability claim made by one of his own patients: If he gives the claimant the nod, he may be accused of conniving against the Government. If he turns thumbs down, he may find himself with one less patient than he had before.

Those were the main arguments against Section 107. Dr. Paullin gave the witnesses' conclusion:

"State welfare agencies are already caring for the disabled worker. They can pass on his worthiness and they have facilities for his rehabilitation. Let *them* handle the job."

To which many a doctor, justly skittish of Section 107, said a fervent amen. END

Had Enough

● The fortyish matron, mother of two teen-agers, came into our office for an examination. She told the doctor she had "missed a couple of periods" and was "just wondering . . ." The doctor's examination revealed she was unquestionably pregnant. Observing her expression of dismay, he tried to reassure her. She was in excellent physical condition, he told her, and should have no difficulties despite her years.

"Oh, it isn't that, Doctor," the woman wailed. "I'm not worried about having a baby. I just don't think I can stand fifteen more years of PTA."

—DOCTOR'S AIDE, IOWA

Your Liability in Accident Cases

What to watch out for when you're called to take care of a casualty

• In this era of supersonic slam-bang, no physician can tell when he'll be called out on an accident. Surrounded by confusion, faced with strangers, he must act fast, yet watch his legal P's and Q's.

What if something drastic, like an amputation, is necessary? Take the 17-year-old Iowan who fell off a freight train and shattered his arm. At the hospital, consultant physicians agreed the arm should come off. The attending M.D., unable to reach the boy's parents, went ahead. Later the parents sued him for failure to obtain consent.

They lost. "The mangled condition of the arm was a menace to the life of the patient," the judge said. "If the surgeon, confronted by an emergency, is not to be permitted to exercise his judgment, the public at large must suffer."

When a conscious adult won't agree to necessary treatment, the doctor's best bet is to get a release acquitting him of responsibility. Ditto in the case of a minor whose parents withhold consent.

A doctor who postpones necessary emergency treatment may be sued for resulting damage. In Kingston, N.Y., a hobo crushed his foot while trying to board a locomotive. Though a rush amputation was indicated, the physician didn't act for ten days. Gangrene set in. Plus that, the bone was left protruding.

In court, the physician contended the patient had never actually employed or paid him. But the patient won damages. Lack of a contract relationship, said the court, was of no consequence in an accident case. Main point was whether the doctor had given proper care.

Malpractice Trap

Consider the Minnesota M.D. called to treat a farmer's wife. He was met at the door by a maid with an injured finger. He hastily prescribed treatment, then went upstairs to his regular patient.

The maid's finger became infected and she sued for malpractice. Finding the doctor guilty, the

[*Continued on* 157]

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* *Milton Tolmach, author of this article, is a practicing attorney and a specialist in medical law.*

Your Practice Wh Yo

Planning a vacation? He e P

before you unlimber th and

You're Away

• Dr. Smith picks up his phone and calls Dr. Jones, down the block. "I'm off next Monday for a couple of weeks' duck shooting, Ed. How about covering for me?"

"Sure. And make mine a mallard."

Arranging for a short-term substitute can be as simple as that. Dr. Smith isn't worried about Dr. Jones swiping his patients, because the two men are old friends. Next month, when Dr. J takes off for a spot of trout fishing, Dr. S will hold the fort for *him.*

Financial aspects of substitution agreements vary widely. While Dr. Smith is away, Dr. Jones may bill the Smith patients as he would his own, pocketing the proceeds in full. Or he may pay Dr. Smith a pre-arranged percentage of such receipts. Again, the billing may be from the Smith office (assuming his secretary isn't taking her vacation at the same time); a percentage of the proceeds would then be paid to Dr. Jones.

In one eastern metropolis, customary payment to the substitute physician is 20 to 30 per cent of the fees collected. Since office overhead is figured at about 40 per cent of gross, such payment is equivalent to from one-third to one-half the net income from the absent doctor's practice. Some practitioners, however, content merely to meet their overhead while they're away, pay their substitutes substantially higher percentages.

If you're going to be gone for some time—say, for a six-month P.G. course—your usual substitute probably won't be able to shoulder your practice in addition to his own. The answer then, of course—in lieu of shutting up shop altogether—is a *locum tenens.*

Here, again, all sorts of agreements are in use. But whatever kind you decide on, *put it in writing.*

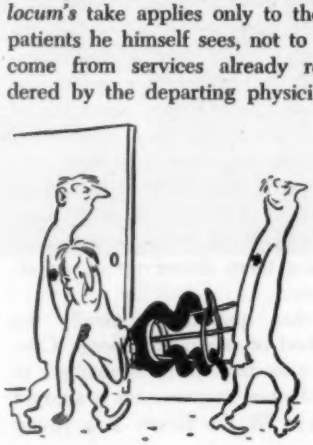
Reports an officer of one large county medical society: "Most substitute agreements are verbal, incomplete, and lead to misunderstanding. They bring on such troubles as failure to pay according to plan, practice-stealing, neglect of patients, improper treatment, etc. We have repeatedly suggested to members that they reduce these agreements to writing, preferably having them drawn up by an attorney."

Prime question is usually the method of payment. George Condit, a medical business manager in Manhattan, recommends a straight salary: "If the *locum* is a young

fellow just out of school, about $500 a month should be fair." If you have a full-time assistant and leave your practice with him, says Condit, a bonus arrangement is often best. He cites the case of an OB man whose assistant took care of several deliveries during the boss' one-month absence; $400 added to the younger man's next check left everybody satisfied.

Most physicians, however—and probably most *locums*—seem to prefer an incentive basis of payment. Sometimes this is combined with a minimal flat guarantee, though a straight percentage proposition is the more usual. A not uncommon arrangement is for the substitute to get 50 per cent of fee collections from the patients he treats, perhaps plus room and board (if he's taking over a home-office set-up).

Obvious though it may seem, it's important to make clear that the *locum's* take applies only to those patients he himself sees, not to income from services already rendered by the departing physician.



Horrible example is the midwestern ENT man who told his substitute, "You can have 60 per cent of everything you collect." Though the *locum's* medical efforts produced a gross of only a few hundred dollars, his prowess as a bill collector brought him in nearly $2,000.

Says Ernest L. Boggs, a medical business manager in Detroit: "The majority of doctors make bad deals in arranging for substitutes. I don't recommend use of a *locum tenens* except in cases of absolute necessity. Even for absences of several months, the doctor is often better off just to give patients a list of qualified colleagues and let them take their choice."

When a *locum* is really necessary, advises Boggs, offer the most generous terms you can, so as to get the best man available. And have him send out his own statements. "This keeps him on his toes. It also means that patients aren't so apt to hold the absent doctor responsible if something goes wrong with the treatment."

What other provisions may be worth including in a *locum tenens* contract? Here's the consensus among medical societies and physicians experienced in such agreements:

¶ Make special arrangements (usually the whole fee to the *locum*) for deliveries and night calls. Also, such special arrangements as may be required for compensation, V.A., and insurance cases.

¶ Specify the exact period of the

contract (with an extension clause if desired). Otherwise the agreement may be too indefinite to be legally valid.

¶ Arrange for the *locum* to make the same fee concessions you make in hardship cases, or for certain types of office visits (post-partum examinations, etc.).

¶ Specify that he refrain from entering private practice in your area for a period of at least two years after the termination date of the contract.

¶ Specify that, in the event of your death, if the *locum* elects to continue your practice, 25 per cent of gross or 50 per cent of net income shall be paid to your heirs for a period of two years.

¶ Fix responsibility for the maintenance of your office and equipment; specify who will pay the cost of repairs or replacements.

¶ Provide for a periodic financial accounting during your absence.

It's a good idea too, one medical society emphasizes, to take out joint malpractice insurance. This should cover your substitute *and* yourself, for the full period he will be practicing in your stead.

A few final tips: Don't plunge your *locum tenens* into new surroundings without proper introductions. A printed notice is one way to tell your patients about the temporary change. Having your pinch-hitter in the office a week before you leave also helps. And while you're introducing him around, don't overlook your colleagues. END

My Aching Practitioner

● Chit-chat about general vs. specialty practice has reached the same stage of futility as argument over one's political party. The chief difference between the medical and the political debate is that the doctor is more apt to champion the *other* fellow's cause.

G.P. and specialist each hail the other's mode of practice. Yet each tries to entrench himself in his own field.

This schizophrenia is well known. The specialist who lauds the G.P. as the backbone of medicine blandly tries to exclude him from the hospital. The G.P., while praising the specialist, lashes out against over-specialization.

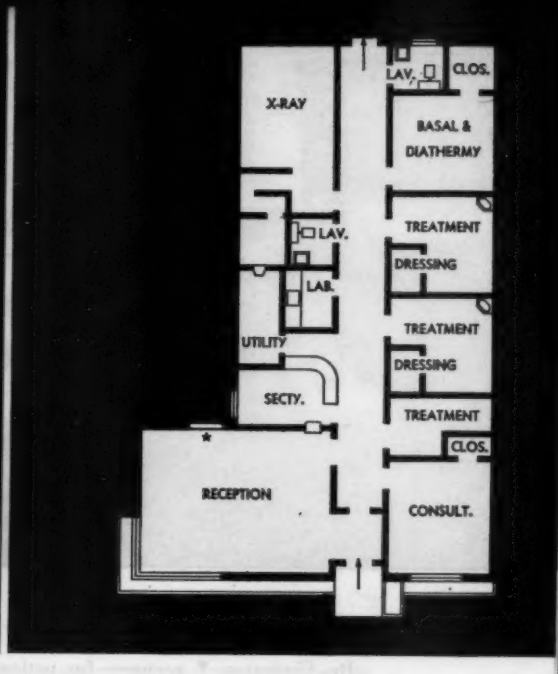
The Army gave impetus to specialty practice; for rank and promotion were often dependent on it. Actually, there was no such thing as a G.P. in the Army. Either you were a specialist or you gave first aid.

Such specialization was often by [*Continued on* 163]

Patients Come First In This Office

● When Dr. C. H. Covington of Selma, Calif., decided to build a professional office, he asked himself, "What can I do to make it appeal to the people who visit it?"

His first decision: the less waiting, the happier the patient. So he included two main treatment rooms, for handling two patients at once. Simultaneously, he can take care of a baby in the small treatment room earmarked for infants. And on extra heavy days, he can shunt a fourth patient into the basal metabolism and diathermy room.



His reception room (see cut on next spread) shows one way he helped insure patient privacy. Other contributions to privacy are (1) a dressing room in each main treatment room and (2) separate lavatories for patients and staff.

He located his secretary (see floor plan) so that ringing telephones and clacking typewriters don't disturb patients. Incidentally, her central location has another merit: A few steps take her to any room in the building.

Possible point of criticism is the lack of windows in some parts, particularly in treatment rooms. But there's good reason for it: A florist shop on the right side provides rental income, and in time a professional office may be added to the left. If so, it can be connected to the reception room by knocking out the already framed-in but plastered-over door (see star on floor plan).

The building provides space of about 17,850 cubic feet. Cost was slightly more than $1 per cubic foot. [*Turn the page*]

Dr. Covington ▼ prepares for patient in one of his two main treatment rooms. Even consultation room ➤ is tuned to patient interests: Farming scene on wall reflects doctor's rural practice

Reception room gives patients more-than-usual privacy. Center island, patterned after designs featured in this magazine, breaks up normal face-to-face seating. ▲ Dr. and Mrs. Covington find antics of tropical fish as fascinating as do patients. Picture aquarium is recessed in reception room wall, tended through cabinet in secretary's cubicle on other side. ▲ Nurse seeks in patient through pass window that opens into reception room.

Should We Legalize 'Mercy Killing'?

An M.D. weighs the pros and cons, comes up with a compelling conclusion

● "I will give no deadly drug to any, though it be asked of me." So reads the Hippocratic oath. So stands the law of the land.

Influential persons are urging that the law be changed. Many doctors believe such a change would neutralize the "deadly drug" line in the Hippocratic oath. After all, they point out, the oath also carries the pledge "not to cut for stone," long since rendered obsolete by the progress of surgery.

Proposed euthanasia laws would allow any mentally competent adult to ask a court-appointed commission of two or three physicians to determine whether he was suffering from a fatal, untreatable, unrelievably painful disease. If the findings were positive, and the patient again personally asked the commission for the release of death, a court-appointed doctor would then carry out the patient's wish. Some proposals would also require the consent of a close relative.

Those who would legalize euthanasia advance these arguments:

¶ It is merciful. The choice is not between life and death, but between an agonizing, slow, inevitable death and one that is quick and painless. We kill suffering animals. Why be less humane to humans?

¶ It would regularize and control a practice that goes on anyway. Said the late Dr. George B. Lake, a Chicago psychiatrist: "Most physicians of wide experience have at one time or another . . . conferred the bliss of death upon a hopeless sufferer." As if to bear out this statement, a well-known New York practitioner, Dr. A. L. Goldwater, announced recently that in appropriate cases it has been his custom to leave a week's supply of morphine tablets at the patient's bedside. "I tell him that if he takes the whole bottle he may not wake up," said Dr. Goldwater. "If this be murder, make the most of it. Every doctor I know has had the same experience."

¶ It would reduce suicide, stop inept mercy attempts by distraught relatives. Distracted family members have been known to do frightful things. In one case a father poured corrosive acid down his son's throat.

¶ It creates an acute economic

problem for the family in furnishing terminal care. This is seldom advanced in public meetings as a justification for euthanasia; but many doctors recognize it. A year of private medical and nursing-home care can exhaust the assets of a middle-class family. It can take their home, deprive their children of college educations, plunge the family into poverty. The patient himself may well be unwilling to see his savings wiped out, his loved ones pauperized, in a futile effort to preserve his painful existence.

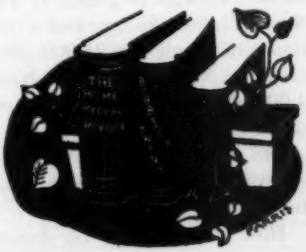
Strong reasons are also cited in opposition to legalized euthanasia. Many physicians insist there is no such thing as unrelievable pain. Nothing need stop the practitioner from increasing the drug dose or decreasing the dosage interval; it should always be possible to keep the patient somnolent. True, a point may be reached where the next higher dose needed to blanket pain may also extinguish life. But, it is argued, a deep moral difference exists between giving a huge dose to relieve pain and giving it with the specific deliberate intent of putting the patient to death.

Again, the march of medicine has transferred more and more diseases from the incurable to the treatable class. Within the life span of many a physician practicing today, diphtheria was inexorably and horribly fatal. Had its victims been given permanent relief by euthanasia at the turn of the century, the stimulus that led to the discovery of an antitoxin would have been greatly weakened.

The so-called safeguard features of proposed euthanasia laws are also widely questioned. The patient's own request for death is said to be a poor criterion. Even a seasick person may express a sincere wish to die. Anyone in racking pain, surrounded by mournful friends and relatives, plunged into transient depression, may plead for death.

A skeptical eye is cast, too, on the board-of-physicians provision. In practice, it is held, this board would lean heavily on the opinion of the patient's regular medical attendant. Thus the decision would actually turn on one man's viewpoint. And this, in turn, would often depend on how an X-ray film was interpreted, how a biopsy specimen was diagnosed, how a clinical picture was identified. Too many false positives still crop up in cancer diagnosis, say euthanasia opponents, to make this a tenable arrangement. In some cases, the malignant or fatal disease would not be found even upon autopsy.

But perhaps the broadest objection is to the *principle* of euthana-



sia. When the chips are down, many doctors simply feel that it's their business and sworn mission to prolong life, not to end it. Let sanction be given to the right to kill certain innocent persons, say these physicians, and it will be swiftly extended to deformed infants, to people with congenital degenerative diseases, and then, by simple stages, to all sorts of "undesirables." With this broadening of the concept would go a decreasing respect for the value and dignity of human life. The gas chambers of central Europe are still fresh in the nostrils of many.

Euthanasia laws now proposed would apply only to untreatable, painful, somatic disease. They would operate only with the consent of the patient. But already some thinkers are suggesting that mental defectives also be included. Such is the view, for example, of Dr. Clarence C. Little, former president of the American Euthanasia Society and currently director of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Me.

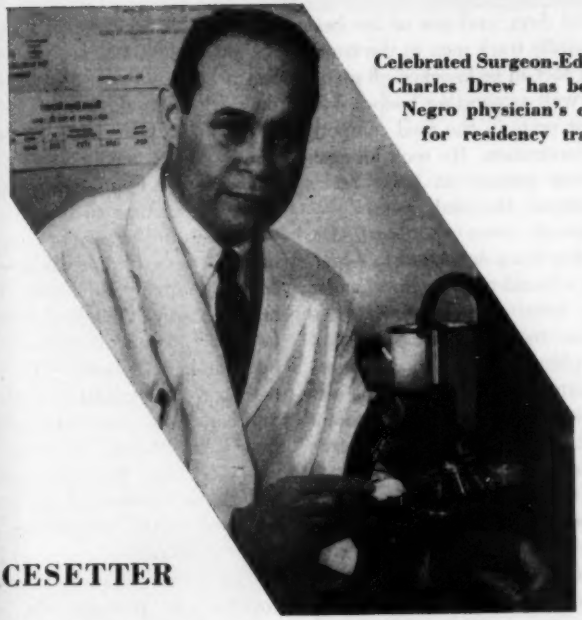
Extent of support by physicians of the legalized euthanasia movement is difficult to gauge. In 1941 the Euthanasia Society sent a questionnaire to all the 25,000 physicians in New York State. Nearly 4,000 answered. Some 79 per cent of these agreed it was "a humane act to shorten the life of a patient suffering from an incurable, painful disease."

How you interpret this depends on where you sit. From one point of view, the figures indicate that only 3,144 out of 25,000 doctors (12½ per cent) favored euthanasia. Yet in terms of the returned sample, affirmative answers (3,144 out of 3,981) amounted to nearly four out of five. Possibly this accounts for the frequent claims of many mercy-killing proponents that the practice is common in the profession.

Not that these claims get by unchallenged. Said Dr. John F. Conlin, director of education of the Massachusetts Medical Society, in answer to such an allegation by a euthanasia-supporter: "An unwarranted slur on the medical profession. There is too much loose talk about the 'common practice' of euthanasia. The truth is that it is the rare physician who kills his patient."

Yet in 1947 a group of 1,776 New York physicians signed a petition asking the state legislature to legalize euthanasia. Signers included such top medical names as Dr. Russell Cecil, Dr. Thomas A. C. Rennie, and Dr. Frederic W. Bancroft. The current president of the Euthanasia Society, Dr. Robert Latou Dickinson, is one of the nation's most noted gynecologists.

On the other hand, many leaders of medical institutions and medical societies are on record as opposed to mercy killings. The list includes Dr. Andrew C. Ivy, vice-president of the University of Illinois; Dr. Warren H. Cole, editor of Surgery, Gynecology [*Continued on* 150]



Celebrated Surgeon-Educator Charles Drew has bettered Negro physician's chance for residency training.

PACESETTER

CLOSE UP

A decade ago, young Negro doctors who wanted to be surgeons were stymied because there was almost no place they could obtain residency training. Today they have access to one of the best such programs in the country, due largely to the efforts of one man: Dr. Charles R. Drew, professor of surgery at Howard University and chief surgeon at Freedmen's Hospital, Washington, D. C. Under his tutelage, Howard has turned out more certifiable Negro surgeons during the past eight years than all other U.S. hospitals and schools put together.

"Only increased opportunities for interne and resident training and for post-graduate education," says Dr. Drew, "will give Negro doctors full range for their abilities."

Charles Richard Drew is himself a man who would have managed to scale the ladder of success with or without rungs. Tall, broad, and biceped, the 46-year-old doctor was an all-American halfback in his

Word was received, as this issue went to press, of Dr. Drew's tragic death in an automobile accident.

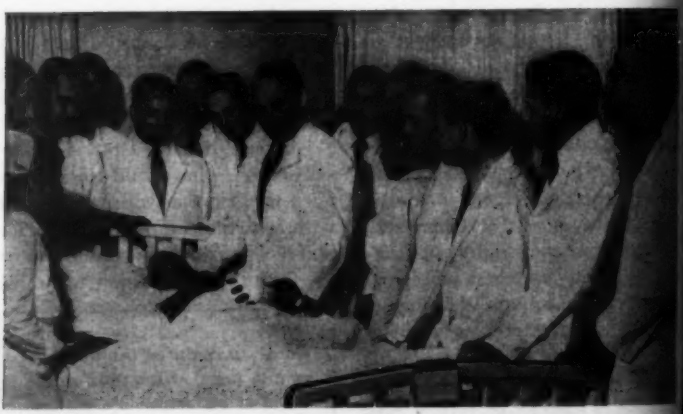
Amherst days, and one of the best high-hurdle track men in the country. At McGill he knocked off medical as well as sporting honors, taking first prize in the final competitive examination. He took his residence in surgery at New York's Presbyterian Hospital.

Although from the start Dr. Drew has been dedicated to teaching, he's found time for spectacular sorties into other fields. His researches in the preservation of blood plasma won him national acclaim during World War II; he was the first to prepare it for shipment abroad. He directed the country's pioneer blood bank at Presbyterian Hospital, setting the pattern for the subsequent network of Red Cross banks. These accomplishments won him the Spingarn Medal and a portrait in Washington's National Museum.

Dr. Drew today makes light of his blood plasma achievements. "At least 300 investigators working down through the years," he says, "each in his turn added a twig to the tree which finally bore fruit. My associate and I simply appeared on the scene in time to pick it."

He sees the erasure of color lines in medicine as a similarly slow process, but equally inevitable. "In the higher realm of medical training," he reports, "most of the walls have been broken. Howard fellows now belong to the American College of Surgeons and take their American Boards in surgery." But the battle won't be won, he says, "until we get greater numbers of our students admitted to the seventy-five white medical schools."

The more Charles Drews the country can produce, the sooner this goal will be reached.



Dr. Drew reviews case with members of Howard University surgical staff

DYNAMO

CLOSE UP

Some months ago, a well-known national magazine decided its readers would go for an article on courtroom testimony. The editor rang up Dr. Henry Davidson, a New Jersey psychiatrist, and told him what he had in mind: a piece salted with true-to-life anecdotes, based on the experiences of expert witnesses. The job would take a week or two, the editor thought. But he added hopefully: "We're in a hurry."

Thirty-nine hours later, a messenger rushed in with Dr. Davidson's manuscript. It had everything: color, humor, authentic court cases. It was so long (7,000 words) that the editor was forced to split the piece into three installments, print them over a three-month period.

What *wasn't* printed was a

Davidson P.S. mentioning that this spectacular output had been achieved "in my spare time." Said the editor resignedly: "No one would believe it. I scarcely believe it myself."

Henry Alexander Davidson, 45, is indeed an implausible lot. Scorning the pipe-and-slippers school of after-hours relaxation, he's made a name for himself as an author, editor, and educator—all in his spare time. His writing exploits (evenings and weekends only) have earned him a niche as one of the profession's crack journalists.

He's written major articles on life in the South Seas, sexual psychopaths, protecting your car against the weather, plantar reflexes, the art of conversation, police surgeons, chess, and the practice of obstetrics. He's even written articles on how to write articles.

This latter series (which, like many of his other writings, appeared in MEDICAL ECONOMICS) began in January 1947 with a memorable piece called "Beware of Medical Gobbledygook!" Frayed reprints of it still top the desks of physician-authors across the land. In typically crisp Davidson style, the article starts thus:

> A professor of English who preached simplicity of style once said, "It is for this generation to reach a definitive conclusion or, perhaps for a century, to forfeit for mankind the chance of making all decisions." Abraham Lincoln said it this way: "It is for us to say whether we shall nobly gain or meanly lose this last best hope on earth."
>
> The man who never had a college education spoke in words of one syllable. And his phrases ring like a bell. The professor's sentence is studded with heavy words like "generation" and "definitive."
>
> A doctor in staff-room conversation talks simply. Yet when scratching that itch to write, he often develops a fondness for fancy language. He wants to be impressive. Instead he is hard to understand.
>
> If you don't believe it, here are some exhibits from manuscripts written by physicians. . .

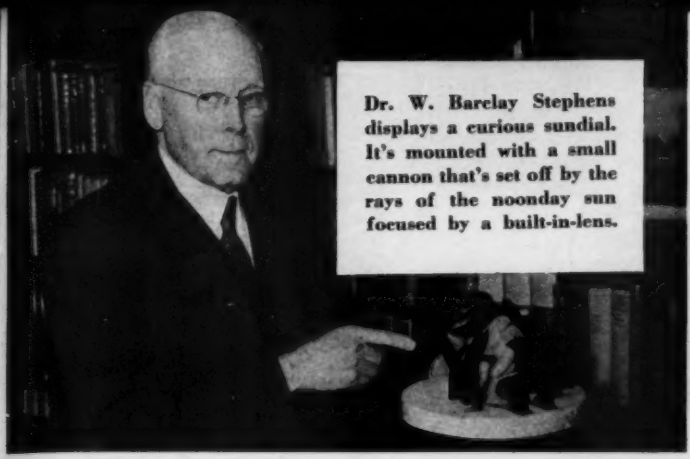
This plea for plain talk made a big splash. Some readers even mailed in their scientific papers for an expert's blue-penciling. Henry Davidson worked a few of them over, mailed them back to their authors. But he shuddered when the first thank-you note came in. It read: "I thank you very much for ameliorating the diction of my thesis."

Since that experience, Dr. Davidson has restricted his editing to the hundred-odd manuscripts a year submitted to the New Jersey state medical journal, of which he's editor—in his spare time, of course. But his writing has taken on new momentum.

Among his varied products are two articles in Coronet (one on suicide, one on criminal responsibility), two Army psychiatric manuals (turned out during a two-week stint in the Pentagon), and a book entitled "A Short History of Chess."

Why chess? He took up the game

[*Continued on* 159]



Dr. W. Barclay Stephens displays a curious sundial. It's mounted with a small cannon that's set off by the rays of the noonday sun focused by a built-in-lens.

WATCHMAN

CLOSE UP

Poking around graveyards seems an odd diversion for a physician. But for Dr. W. Barclay Stephens of Alameda, Calif., it's strictly pleasure—a little field work for his hobby of horology. Gathering vital statistics on departed watchmakers, often available only from their grave markers, is all part of the game, reports this 81-year-old retired ophthalmologist.

Tombstones, however, play second fiddle to timepieces in Dr. Stephens' affections. His collection of some 400 watches includes many masterworks of ingenuity. His favorite watch dates from 1640, before steel hair springs were available. That didn't stump the maker of this particular timepiece: He used a hog bristle.

The doctor also has over 100 clocks, plus some fifty sundials, hour glasses, and other ancient devices used in man's efforts to be punctual. Books and watch-making tools make up the rest of the 900-item collection. For the benefit of future horologists, Dr. Stephens is donating it, little by little, to the California Academy of Sciences, of which he is an honorary curator.

Dr. Stephens' hobby has practical value, too. Once he helped a marine biologist who was trying to keep one eye on some fish, the other on his watch. Dr. Stephens' remedy for incipient diplopia: a home-made timer that bonged melodiously at regular intervals.

During his fifty-two years in practice, Dr. Stephens enjoyed horology as a "wonderful relief" from the stress of professional life. Now, in retirement, it's given him a valid excuse for doing what many folks do on the sly—clock-watching. END

Emergency Medical Service

Date and Hour of Incoming Call 11/19 7:

Name of Person Calling Otto Seeb

Name of Patient Mrs Otto See

Child ☐ Adult ☒

Nature of Illness Diabetes

Address 3107 E 69th St

Telephone No. 01-667

Family Physician Dr. Stoney

Have you called him? Yes ☒

Call Referred to Dr. Otto All

Mrs. Fanny Long ⮜, switchboard operator at Erie's Hamot Hospital, gets emergency call for doctor. She jots down facts on printed slip ⮞, relays them to physician on duty.

An Emergency-Call P

● It was last Christmas Eve in Erie, Pa. George Kelley, CIO leader, and his wife were entertaining friends. Around midnight one of them keeled over with violent pains in the abdomen. The family doctor was unavailable, but a call to the emergency service of the Erie County Medical Society brought an M.D. within half an hour. A few days later the patient underwent surgery for perineal hernia, subsequently made a good recovery.

One result: an editorial in the People's Press, local CIO newspaper, lauding the city's doctors as men "who will not let their fellow citizens down."

Contrast this with the much-publicized account of the West Coast veteran who clung to a telephone for seven hours before he finally got a physician for his stricken father. By that time, it was too late.

That could have happened in Erie two years ago. But alert practitioners, hearing of similar incidents, decided to lock the barn door *before* the horse was stolen. They set up an emergency-call program of the type that's helping

Dr. J. W. Blevins ▼ receives message from operator. He phones patient's home, decides case warrants personal visit. Another Erie doctor, M. I. Engel ▶, completes mission.

Plan in Action

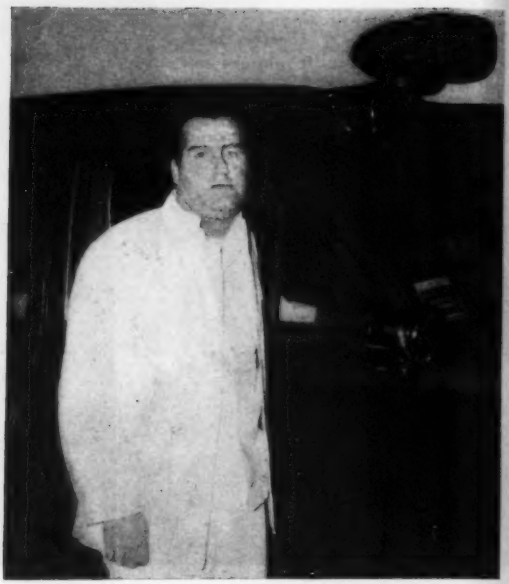
medicine win friends and silence socializers the country over.

Of the county society's 200-odd members, thirty-six volunteers make up the emergency corps. Six are on continuous call in suburban areas (population 40,000), where their names are posted with each telephone company operator. Of the other thirty, each is on duty one day a month in the city proper (population 140,000).

Although G.P.'s are the backbone of the service, six specialists have also joined their ranks. Explains Dr. P. F. Eastman, general surgeon: "It's a good opportunity for me to see some of the problems of general medicine with which I otherwise would have no contact."

The plan works like many another of the nation's several hundred emergency services run by local medical societies. To take an actual case:

A diabetic, whom we'll call Mrs. Otto Seebury, is taken ill. Her husband, unable to reach their family doctor, recalls newspaper advertisements of an emergency medical service. He looks it up in the physi-



Fewer wild goose chases for ambulance drivers is one result of Erie's emergency call program. Says George Smith of St. Vincent's Hospital: "Many's the time we used to come back with an empty ambulance. Now we go out about half as often and seldom make a dry run."

cians-and-surgeons section of his classified phone book, dials one of the two numbers listed (private lines to each of Erie's two general hospitals).

The hospital switchboard operator jots the facts of the case on a printed form (see cut on preceding page). She checks to make sure the caller has tried to contact his family physician.

Instructing Mr. Seebury to stay by the telephone, she rings the physician-of-the-day, Dr. Potts. He's on a house call. She tracks down his alternate, Dr. Allen. He phones Mr. Seebury, decides his wife requires a personal visit (four out of five do), and attends the case.

The following morning at 8 o'clock, Dr. Allen takes over as physician-of-the-day. His hitch lasts twenty-four hours. On New Year's Day and Christmas, assignments are split into eight-hour shifts. Each M.D. serves about once a month.

Sometimes the city's younger practitioners ask for more frequent duty, easing the load on the others. Sundays and holidays are rotated.

Each doctor is notified of his next duty date several weeks in advance. Another reminder is mailed him a few days before his stint begins. If he finds the date inconvenient, it's up to him to get a substitute. He must also let the two hospital phone operators know of the switch.

During a physician's tour of duty he can expect three or four emergency calls (Erie's average: about 100 a month). Heaviest load is during the summer; on holidays, Sundays, and Wednesdays (regular day off for Erie practitioners); and at night.

Record: 15 Calls a Day

The record for a single twenty-four-hour period was fifteen calls one day in July 1949. Few requests come in during daylight hours. Erie doctors like this, since it means they are seldom called from their regular practice rounds.

Minor ruffles are taken in stride. One morning recently, for example, the physician-of-the-day was performing an operation when a message for medical help came through. His alternate couldn't be reached. The hospital operator had to dial five numbers before she could get a doctor.

Usually, however, the caller hears from a physician in short order. A record was set one morning during the pre-dawn hours. The physician-on-duty had just handled one emergency case, was leaving the hospital when the switchboard girl flagged him again. He reached the second patient's home in five minutes flat.

Cost: $200 a Year

Cost of the program averages slightly more than $200 a year. This is absorbed by the county society without additional charge to members. It covers payment for the two telephone lines, listing in the classified section of the telephone book, printed forms, and postage. Use of switchboards is donated by the hospitals.

Recruiting physician-volunteers was not easy at the start. A number of doctors turned thumbs down on the idea. Others were undecided. Commonest query: "How often will I have to be on duty?"

The organizing committee decided to put the question this way: "Would you be willing to serve once a month?" At the end of seven days, thirty-two M.D.'s had answered yes.

Doctors who participate have the satisfaction of giving a real public service. But there are practical rewards too. Says Dr. M. I. Engel: "I've found it a good way to make friends and build up practice."

The society is taking no chances that the plan will fizzle for lack of future replacements. Applicants for society membership are quizzed on their willingness to take part. If

Advertisements like this appear every six months in Erie County newspapers. Along with occasional feature stories, they help keep public aware of emergency plan. Latest plugs come on local medical society's television show.

the answer is no, the board of censors decides whether the candidate's reasons are acceptable.

Most participating physicians report collections of close to 95 per cent. Basic charge is $5, which the doctor may raise if the treatment warrants. As an experiment, switchboard operators now tell patients, except in obvious rush cases, what they're expected to pay (provided, of course, that they can afford it). Thus, the physician doesn't have to explain that there will be a charge for the service.

Since this innovation, one practi-

tioner made fifteen calls during a twenty-four-hour shift, collected $75 without once asking for payment.

About 75 per cent of the plan's users have family doctors. Only one out of ten asks for aid without trying to contact his own physician first. "I don't want to bother him" or "He doesn't make night calls" is the usual excuse. In this event, the switchboard operator calls the family doctor before turning the case over to the physician-of-the-day.

Little Loafing

Are physicians tempted to slough off inconvenient calls onto the emergency panel? One says that a few M.D.'s "use it as a vacation service." But Dr. Ralph E. Schmidt, chairman of the emergency program, while admitting that several such cases cropped up at the start, says they seldom occur now. "Participating doctors don't hesitate to reprimand delinquents," he explains.

Before the service went into operation, there was no alternative, on a hospital call, but to send an ambulance when requested. Now the physician-on-duty usually decides whether one is needed. The result is a marked decrease in ambulance pick-ups. Needless to say, the hospitals are 100 per cent behind the plan.

Erie citizens have become so used to the service that they tend to take it for granted. But there are still times when praises flow freely.

Early this year, for instance, a woman was attending a church function when she got word from home that her husband was ill. The minister phoned the emergency service. The doctor-on-call soon arrived at the church, picking up the wife to show him the way to the house. His prompt response to the call was later extolled by the preacher among his flock.

Public Relations

Says Dr. J. F. Hartman, the local medical society's president: "The program is our outstanding example of good public relations."

Adds another medical leader: "The service is the cheapest insurance policy available. Where else, for $1 a member a year, could we get these benefits: a guarantee of good-will; protection of the patient's welfare; freedom from worry if the family doctor isn't available; and pride in knowing that a worthwhile public service is being done well?"

—ALLEN ELY

Ten Ways to Invite Malpractice Action

Missteps that send M.D.'s to court range from sloppy records to ambiguous advice

● Statistically speaking, it's twenty-five to one you won't be sued for malpractice this year. But with some 5,000 cases tried annually (and thousands more settled out of court), every doctor must face the fact that it may be his turn next.

Oddly enough, many a suit is filed practically at the physician's invitation. Here are ten easy ways to get yourself a summons:

LAWSUIT INVITATION #1: *Don't bother to get proper consent.* Radical procedures on legal incompetents are a prime malpractice trap. The psychiatrist performing shock therapy, for instance, must not only have consent but be prepared to show that the patient knew the score when he gave it.

Children are a more common source of litigation. Take the Texas physician who removed the adenoids of a 10-year-old boy on the go-ahead of his grown-up sister. Result: a successful suit for personal trespass on the youngster, brought by the parents.

Again, a doctor performed an autopsy on a child with the say-so of its father, normally the best source of consent. But the mother won damages. It turned out that the couple were separated and she had legal custody of the child.

A frequent consent poser arises when a surgeon must depart from an agreed operation. An Oklahoma physician told a patient he had to make an incision in the foot to drain out pus. Once started, he found an infected sesamoid bone over the tendon. In line with sound surgical practice, he removed the bone—thus exceeding consent. Had he obtained permission to do "whatever was in the best interests of the patient," he'd have been in the clear. As it was, he paid—despite expert court testimony that he could not possibly have drained the infection without removing the sesamoid bone.

With an unconscious and unidentifiable patient, the physician may do whatever is necessary to preserve health or life. Under these circumstances, consent is implied. In all other cases, get broad and clear consent—preferably in writing. If the patient is a minor or an incompetent, the consent should be obtained from his legal guardian.

LAWSUIT INVITATION #2: *Keep*

careless records. A patient was burned when he applied full-strength a lotion that should have been diluted with water. The doctor asserted he told the patient to do so; the patient denied it. The doctor had dispensed the preparation himself, had no prescription blank to support him. His office records, however, *did* clearly indicate he had given such instructions. They saved him a trip to court.

Well-kept records can avert other malpractice headaches. Suppose a patient is urged to return for further treatment, but fails to show. Later he relapses, then claims malpractice. If the doctor can prove he warned against interruption of therapy, the plaintiff has no case. Adequate evidence would be a carbon of a letter reminding the patient of the need for follow-up treatment.

Sometimes a suit turns on dates of treatment—particularly where the doctor is pleading immunity under the statute of limitations. Detailed office records will generally prevail over a patient's recollections.

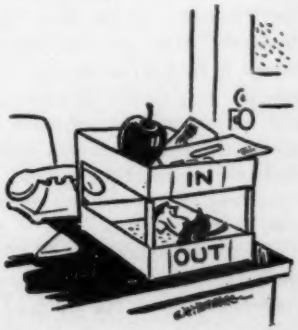
Good recording has further professional value. In a malpractice action, office documents often go before the jury as exhibits. Slovenly records do not necessarily mean a slovenly doctor—but a jury is apt to think so.

LAWSUIT INVITATION #3: *Be vague about instructions.* "Of course you know how to make a turpentine stupe," says the doctor; or "how to prepare a mustard plaster" or "set up a vaporizer." Sometimes a physician will even advise medication "whenever the pain comes on," with no warning as to dosage maximum.

A Wisconsin jury brought in a verdict against a practitioner who told a patient to "remove the ointment when it burned." Unfortunately, he neglected to make clear how strong the burning sensation should be or just how to get the ointment off.

Failure to tell what side effects to expect from medication is another way to wind up before the judge. A Michigan physician gave an alcohol injection to relieve a patient's sciatica. The procedure was highly successful, stopping all pain. But it also stopped all power in the leg for a time.

The patient became frightened and summoned another doctor. Later he demanded damages of the first M.D. for his additional medical expenses as well as for his men-



tal anguish when he thought himself paralyzed.

The judge told the jury it could bring an award against the defendant "even though the treatment was proper and careful, if the physician did not advise the patient in advance of the probable consequences of the injection." The jury followed the judge's advice.

LAWSUIT INVITATION #4: *When you take a vacation, let the patient find himself another physician.* A Kentucky doctor performed a tonsillectomy one morning a few years ago. He sent the patient home early that afternoon. Then he departed on a brief holiday, neglecting to name a *locum tenens.*

When the patient's throat started to bleed, the family spent a frantic half-day trying to locate the surgeon or find out who was taking his calls. Result: a malpractice suit based on the physician's failure to make covering arrangements. Such an oversight, in the eyes of the law, can be negligence.

LAWSUIT INVITATION #5: *If you don't like the case, drop it.* The law has a harsh word for this—"abandonment." True, you don't have to accept a patient at all. But, once you do, you cannot absolve yourself of responsibility without (a) giving the patient enough time to find another practitioner; and (b) furnishing the necessary medical care in the interim.

LAWSUIT INVITATION #6: *Mind your business and let your assistants mind theirs.* The catch: Their business *is* yours. A nurse, assistant, technician, or other office employe is legally the doctor's agent. If the assistant is negligent, the patient can sue the assistant *or* the physician—or both. Since the M.D. has more money, he's the usual target.

Most malpractice policies cover the doctor for suits based on employes' negligence. But it's a good idea to check your policy for this clause at each renewal date.

If a nurse in a doctor's office gives an injection improperly, the physician is liable. In hospital practice, it must be determined whether the nurse is the agent of the doctor or of the hospital. If the latter, the physician will not be held responsible—unless the nurse or other assistant acted directly on the doctor's orders or under his direct control.

For instance, a hospital patient's back had been strapped, but the attending physician decided to apply a cast. He instructed a nurse to remove the adhesive. Using a fluid softener, she peeled it off while he stood by. Later the patient complained of severe pain. The cast was removed and burns were found, traceable to the caustic softener.

"It was the duty of this physician," said the court, "to see that every act under his supervision was properly performed. The nurse was under the immediate control of the physician, notwithstanding that she was a hospital employe. Judgment

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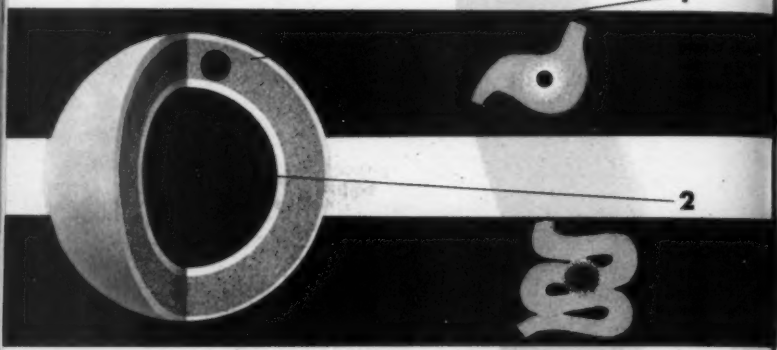

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references

1. McGavack, T. H., and Klotz, S. D.: Bull. Flower Fifth Ave. Hosp., 9:61, 1946. 2. Weinberg, J., et al.: Am. J. Digest Dis., 15:332, 1948.

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against the defendant is affirmed."

LAWSUIT INVITATION #7: *Make a habit of prescribing by telephone.* When the weather is bad and the distraught mother pleads for something for baby's earache, it's tempting to suggest some harmless local medication by phone. Why plunge out into the storm, only to prescribe the same thing anyway? Reason: the mother may misunderstand instructions, use the wrong preparation, or push it into the ear on a swab. Telephoned instructions or prescriptions are always malpractice bait. Consider what happened to this Vermont practitioner:

A woman called to say her child's scalp was covered with mosquito bites. The M.D. phoned a druggist, asked him to deliver her some mild chloride of mercury. The druggist understood him to say "bichloride" of mercury. Since he had no written Rx, he didn't know the age of the patient; and the label, he was told, was to be simply: "Use as directed." In the resulting court melee the jury fixed the blame wholly on the physician.

LAWSUIT INVITATION #8: *Put on pressure to collect a fee.* One type of deadbeat, pressed for payment of a medical bill, likes to allege that the case was bungled, hint darkly at malpractice action. This, of course, is supposed to frighten off further collection efforts. The doctor who refuses to be frightened must, of course, be prepared to see the cornered patient carry out his threat. While most such cases are disposed of before they reach the docket, the M.D. may have an uneasy few months sweating out a settlement.

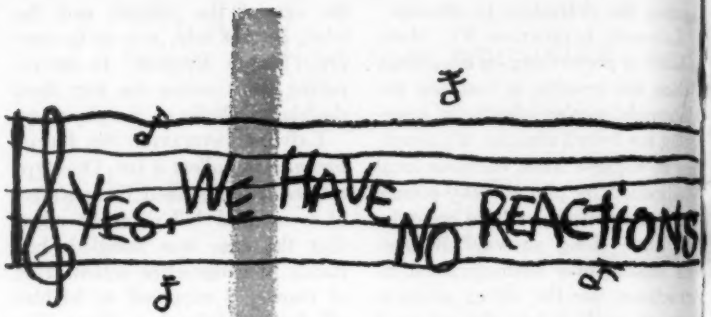
In this game, however, time is on the side of the doctor. The statute of limitations governing malpractice suits is usually shorter

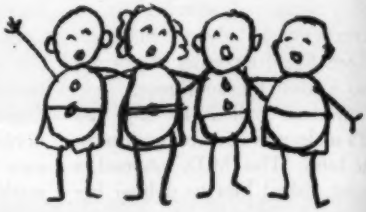
One Too Many

• While a medical student, I was attending gyn. clinic with a small group of my classmates. The instructor was discussing the patient's problem, chronic P.I.D. Suddenly the attractive young blonde looked up from the table, fixed her gaze on me, and said: "Is your name Smith?" I conceded that it was and, wondering who she was, glanced over at her chart. It showed that she came from a village right next to my home town.

After a brief silence, the girl asked: "Are you Robert?" While my classmates choked and sputtered, I replied: "No, he is my brother." "Oh," said the girl, "*he's* the one I knew."

—M.D., INDIANA





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than the time on contract bill payment actions. If, for example, the periods are two years and six years respectively, the patient must start action within two years of the last treatment,* but the doctor can sue for payment any time within six years.

A physician planning legal recourse on an unpaid bill may sometimes be wise, therefore, to await expiration of the statutory period for malpractice action.

LAWSUIT INVITATION #9: *Whistle when you see the scar.* Some doctors open themselves to litigation through their own unguarded remarks or reactions. For example, palpating an abdomen: "Too bad I couldn't get here a couple hours sooner"; or, probing for a splinter, "Oops . . . clumsy of me!"

Libel action, just around the corner from malpractice, may spring from some such careless utterance as "Her pains are imaginary."

Again, the physician may issue his invitation for a suit via the mail. His letter of righteous indignation, in reply to a patient's accusations, merely plays into the hands of the latter's attorney.

One doctor received this letter: "I certainly won't pay your bill. Ever since you stuck that needle in my spine, I've had terrible headache with palsies up and down the legs."

The M.D. hastened to reply that the spinal tap had nothing to do with these symptoms; that he'd taken care to sterilize the injection site with alcohol; that he'd done a dozen spinal taps and never yet had had an infection; that if the patient had a headache it was because she didn't remain in bed for twenty-four hours after the lumbar puncture.

When the complaint was filed, the doctor was flabbergasted to see such allegations as: "He sterilized the skin only with alcohol, instead of using tincture of iodine . . . he was inexperienced in this procedure, having done only twelve taps in his entire career . . . he was negligent, in that he failed to instruct the patient to remain in bed after the puncture."

Moral: The only safe answer to a disgruntled patient is "Write to my lawyer."

LAWSUIT INVITATION #10: *Let them know you're covered.* "Don't worry about that burn. I have $50,000 insurance to take care of such things." An R.S.V.P. to trouble, this, putting even the friendly patient in a litigious frame of mind.

True, when a case reaches court, everyone, including the jury, usually knows well enough whether the doctor is insured. In most jurisdictions, though, open revelation of such information before a jury is enough to cause a mistrial. In any event, careless or boastful disclosure by the doctor of his malpractice coverage is inexcusable.

—HAROLD RAVESON, LL.B.

*If the patient is a minor, the limitation period usually does not begin to run until he's 21.

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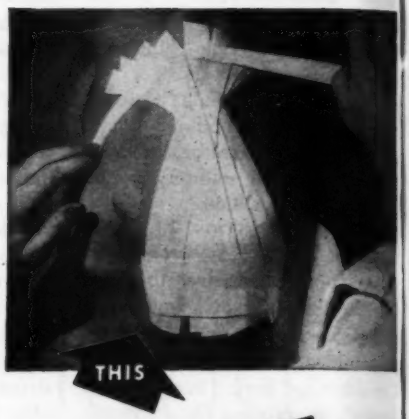

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RESEARCH TO IMPROVE TECHNIC . . . TO REDUCE COST

Laymen Rally to AMA Stand

Rising protest against compulsory health plan is potent election year force

• Like spring showers, resolutions against compulsory health insurance are raining down on Congress at the rate of fifty a day. And signs are that the AMA drive to induce organizations to mail and wire their protests to Washington is only beginning to gather force.

So far, about 7,500 local, state, and national groups—ranging from the American Legion to Xi Psi Phi fraternity—have voiced their opposition to the Administration's health plan. By the end of June, the total is expected to hit 10,000.

Says National Education Campaign manager Leone Baxter: "In determining Congressional action on legislation affecting the profession, no work is more important than building allies."

Lawmakers' comments indicate that the protests are belting home:

¶ Says Senator Homer Ferguson (R., Mich.), "This gives me excellent information on the feeling of the people in my State."

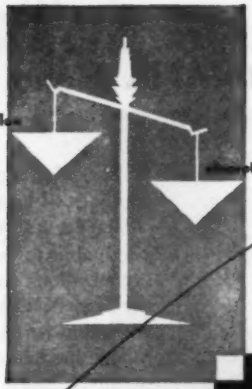
¶ Senator Hugh Butler (R., Neb.): "I am impressed by the number of groups on record against compulsory health insurance."

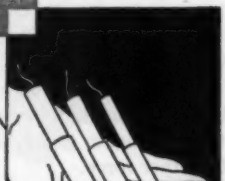
The AMA endorsement campaign aims to enlist all sympathetic organizations from the smallest to the largest. Reason: Every time a resolution is read aloud before any group, medicine's cause gets more publicity, more supporters.

Large portion of the drive's success to date is attributed to contact work carried on by doctors' wives. Says Miss Baxter: "Some of the best work has been done where close liaison exists between the auxiliaries and their medical societies."

Among the 161 national organizations supporting the AMA stand: the American Bar Association, U.S. Chamber of Commerce, General Federation of Women's Clubs, American Council of Christian Churches, Veterans of Foreign Wars, American Farm Bureau Federation, National Grange, National Association of Retail Grocers, Daughters of the American Revolution, National Association of Real Estate Boards, and the American Association of Small Business.

Says Miss Baxter: "The supporting voice of friendly organizations and their millions of members is the *real* 'lobby' we want to present to Congress." —J. D. OBERRENDER





so adequate

There's a wide safety margin between the amount of menstrual flow* and the absorptive capacity of TAMPAX tampons—a fact strongly substantiated by the purchase of more than two billion TAMPAX in the past twelve years. The comfort and convenience of the three absorbencies of these dainty intravaginal cotton guards (with individual applicators) are also strongly appealing.

*Am. J. Obst. & Gyn., 31:979, 1936.

TAMPAX INCORPORATED · PALMER, MASS.

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

ME-5

TAMPAX

the internal menstrual guard of choice

Your request will bring professional samples promptly.

Climax Near in Anti-Trust Test Case

Spotlight focuses on Oregon pilot suit as trial moves into final stages

• Will the Government's anti-trust probe of the medical profession fizzle? Or will it pave the way to still bigger investigations and, thus, still more grist for the socializers' mill? The answer may hinge to a large degree on the outcome of the Justice Department's "conspiracy" suit against Oregon physicians and medical societies.

With all testimony in and only closing arguments to be heard, the case has moved into its final phases. Court observers expect a decision to be handed down sometime after September 1.

A judgment for the Government presumably would result in injunctions against the defendant medical organizations. These might instruct them to cease boycotting commercial hospital and medical health plans.

To prove its main contention that eight Oregon physicians, the state medical society, and eight county societies had conspired to monopolize prepaid medical care with their own doctor-sponsored plan (Oregon Physicians Service), the Government called forty-nine witnesses (but only a handful were physicians) and offered 2,225 documents in evidence.

One physician testified that he was ousted from his county medical society for treating patients of prepay medical plans. Another asserted that he was prevented from becoming a member for the same reason.

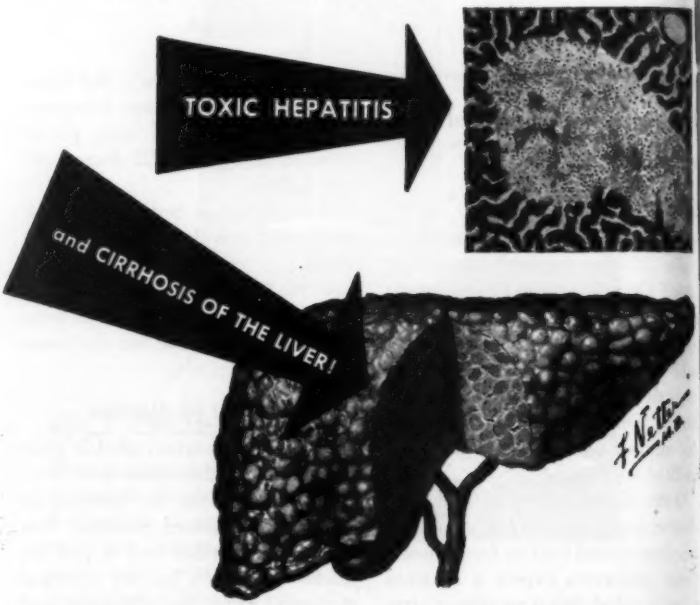
Boycott by Doctors

Hospital association officials gave this picture: Physicians had boycotted their plans by refusing to bill the associations directly. This meant a subscriber had to pay his doctor bill, then get an itemized statement from the physician and present it to the association for payment.

The resulting inconvenience was said to have miffed subscribers, caused many industry health contracts to be turned over to the Oregon Physicians Service. According to other testimony, many associations felt the pinch, some of the smaller ones were forced out of business.

The pattern of defense testimony was set by the very first witnesses. They denied indignantly and em-

A true metabolic corrective for



Considerable literature has accumulated attesting the importance of methionine to proper fat metabolism in the liver. Indeed, methionine has now been established as one of the essential lipotropic amino acids. In its absence, fatty degeneration followed by cirrhosis tends to develop in the liver. Most significant, however, is the fact that the administration of methionine to patients with such hepatic disorders has proven to be exceedingly beneficial and even life-saving in many cases. Thus, in a series of cirrhosis patients with ascites, only about 27% were alive after two years. On the other hand, of those cirrhosis patients treated with methionine, over 88% survived and a goodly percentage of these were able to resume their normal activities.

Methionine Armour

is indicated for infectious or toxic hepatitis as well as cirrhosis of the liver. The dosage varies with the individual case and is usually between 2 and 10 grams daily. Methionine Armour is supplied in tablets of 0.5 gram, bottles of 100.

Have confidence in the preparation you prescribe—specify "Armour"

ARMOUR *Laboratories*

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

phatically that individual doctors had been coerced to boycott the commercial hospital associations.

Dr. Edwin R. Durno, a Medford, Ore., physician, minced no words in explaining why he had ceased to cooperate with the lay organizations: (1) The pay was "not in fair accord with the practice and services rendered"; (2) any patient requiring extensive treatment or a major operation was "urged to come to Portland [Oregon's only large metropolis, some 300 miles away from Medford] for treatment"; (3) the doctor had to "request authority from a layman" before proceeding with any major treatment.

Dr. John H. Fitzgibbon, an individual defendant, objected to "a third party layman as an intermediary between me and my patient . . . who makes a profit out of it . . . We wanted to set up a service [OPS] on a high ethical level . . ."

Complained Dr. Raymond M. McKeown: "They told me when to do GI studies, when to take X-rays, and when to do surgery."

No Prompting

Defense witnesses—with varying degrees of anger, sorrow, contempt, and belligerence—testified that they had made up their own minds about the commercial hospital associations. They were not, they insisted, prompted by any urgings of their county or state medical society or the American Medical Association.

Most testified at length about difficulties with the lay-owned groups. They explained that they frequently had to accept percentage reductions on bills and had to get permission for treatment.

It was different with their own plan (OPS), they said, because they didn't have to deal with lay persons. A few admitted they were aware of county society policy or feeling against the commercial hospital associations. But they denied this had any effect on their own thinking.

"Political Trial"

An outspoken Portland physician, Dr. K. H. Martzloff, one of eight individual doctor-defendants, charged "smear tactics" and a "political trial."

Said the doctor: "This is just an effort to smear the medical profession by the political coterie . . . representing the Red wing of the Federal administration." These comments, however, were stricken from the record.

Many physicians testified that they still cooperated with lay hospital organizations by billing them directly for services to patient-subscribers. The doctors added that no coercion was used to stop them from doing so. In several instances, however, they had at one time or another discontinued this practice for a period.

Government exhibits included letters in which several of these practitioners had said they were

Carnation Gives You Uniform Control in all 3 Feeding Stages

1. BABY'S FORMULA

You can prescribe the combination of milk, water and carbohydrates that fits each baby's individual needs—secure in the knowledge that Carnation Evaporated Milk *never varies*. And you know it is absolutely safe. For it is not only pasteurized, but sterilized *after* the airtight can is sealed. There are no "unknowns" in the formula to cause complications at this critical stage of the infant's life.

2. POST-FORMULA FEEDING

Delicate little digestive systems are still easily upset after baby goes off formula, so Carnation's absolute uniformity continues to be an important safeguard. And Carnation diluted with an equal amount of water is nourishing whole milk in its most digestible form. For Carnation is homogenized and heat-refined—is *soft-curd* milk that the baby can readily assimilate.

3. CUP-DRINKING

Here's an important plus all doctors (and mothers!) appreciate: When *familiar-tasting* Carnation is used in the cup, baby makes the radical change-over from bottle-feeding with far less resistance. Here again, Carnation's constant uniformity in butterfat, milk solid content, curd tension, and viscosity is a positive factor in eliminating the possibility of digestive upsets.

Complete Control—that's the secret of Carnation's absolute uniformity. Every drop comes from cows checked by Carnation's own inspectors ...is tested in Carnation's own receiving stations...is pasteurized and processed with prescription accuracy in Carnation's own evaporating plants. There is no finer, safer milk for babies...none that gives you better control over all three stages of baby's feeding. When you recommend Carnation *by name*, you specify the milk that has been a standard among doctors for over half a century.

8 out of 10 mothers raising their babies on Carnation report that it was recommended by their doctor

The Milk Every Doctor Knows

"From Contented Cows"

conforming to county medical society practice. Among other government documents were minutes of a number of medical meetings in which the subject had come up, along with minutes of disciplinary proceedings against doctors who had been closely connected with lay associations. However, the defense pointed out that the most recent meeting cited was in 1941.

As rebuttal witnesses, hospital association officials testified that the doctor-boycott still existed against them. In some instances friendly doctors dealt with them in such a way as to conceal such dealings from their medical societies, it was charged.

More "Medical Trusts"

Meanwhile, West Coast physicians were watching two similar suits brought by private groups. In San Diego the Complete Service Bureau, a nonprofit, prepaid plan association, had charged that the county society is a "medical trust" aimed at controlling the practice of medicine. It had asked that the society (1) pay $200,000 damages; (2) be restrained from allegedly obstructing the free availability of medical and hospital services; and (3) be required to admit all qualified physicians as members.

The county society countercharged that the bureau sought to create a medical monopoly and that its subscribers "do not have free choice of physician and surgeon."

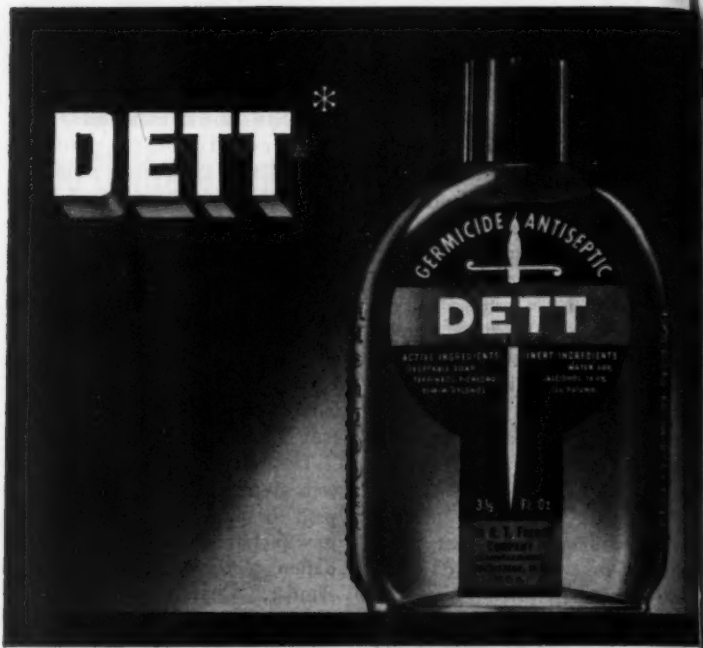
In Seattle, a health cooperative and a group of doctors are pressing a suit against the Seattle-King County Medical Society, the King County Medical Service Bureau, and The Swedish Hospital.

The defendants, it's alleged, have conspired to get a monopoly on prepaid hospital care, have sought to wipe out competition by "intimidation, coercion, threats, libel, and slander." Charges also state that some members of the cooperative have been barred from the county society. The cooperative seeks a permanent injunction to enjoin these alleged practices and asks a $79,500 judgment. END

Nocturnal Nugget

• About 2 A.M. one winter night, Mrs. X called me up and said: "Doctor, can you come over right away? I have a terrible toothache." As politely as I could, I answered: "My dear lady, what you need is a dentist, not a physician." To which Mrs. X replied: "Yes, I know—but I just hated to call a dentist at this hour."

—DOUGLAS B. BLACK, M.D.



*ALSO KNOWN AS DETTOL

A "new" Antiseptic proved by 20 years performance

New to the medical profession of the United States, Dett, under the name Dettol, is standard equipment for surgeons and hospitals throughout the British Empire. Dett, for obstetrical and surgical use, has been proved since 1929.

Dett, although deadly to germs, is gentle to human tissue. This clean, clear liquid with an agreeable odor is safe, effective, non-irritating and non-staining. Physicians who have used Dettol in other countries will welcome its introduction in the United States under the name of Dett.

For a generous size sample, and literature, write to: The R. T. French Co., Pharmaceutical Department, Rochester 9, New York.

DETT *THE MODERN WEAPON AGAINST INFECTION*

Brass Tacks About Air Conditioning

Facts and figures on this means of bolstering your summer practice

● Will you be conducting a twentieth century practice in an eighteenth century atmosphere this summer? That's no joke. For on hot, humid days your most modern techniques will mean less to your patients than a breath of cool air.

What's needed is a liberal dose of air conditioning. So here's a reminder of its significance in a medical office:

It controls temperature and humidity. This means:

¶ Better working conditions for you.

¶ Better waiting conditions for your patient.

¶ Easier diagnosis and treatment because the patient is relaxed.

¶ Less spoilage of drugs and X-ray film.

It ventilates. This means:

¶ Windows can be kept closed and street noises shut out.

¶ There are no disturbing drafts.

It cleans the air. This means:

¶ Dirt is kept to a minimum; you have fewer cleaning bills.

¶ Unpleasant odors are wafted away.

¶ There's relief for asthma and hay-fever sufferers.

Available equipment ranges from self-contained units to central systems. The choice for your particular office is best made with the help of an air-conditioning specialist. Meanwhile, here are some general hints:

Tailor-made Weather

A single room is served best by a self-contained unit, commonly called a room air conditioner. The most compact model (14″ x 26″ x 26″) fits snugly into a half-open window. Since the air is cooled by a hermetically sealed refrigerating unit, this conditioner requires only electricity. Plugged into any outlet, it can air condition a room up to 200 square feet in area. Cost: about $300, installed.

Larger window units sell for about $400, but if your room is over-size, you'll probably need a console model. This type sits on the floor, but it takes relatively little space. One such unit measures only 40″ x 34″ x 21″.

While most console models operate on electricity alone, some need water as well. Those with plumbing connections cost a good deal

THE SIMPLE, BLAND, STERI *Dressing*

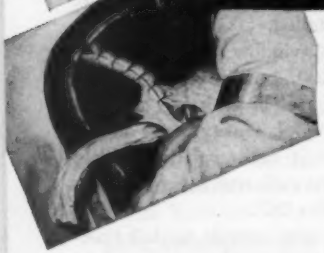
FOR...

cover

—non-adherent, lubricant, emollient, and *sterile* dressings for burns and wounds of traumatic or surgical origin

pack

—non-toxic, non-macerating, separable, and *sterile* packing material for post-operative plugs, packs, rolls, and tampons



drain

—non-irritating, non-sticking, pliant, and *sterile* material as wick or drain or wrap-around for tubing.

Always ready—always sterile: *VASELINE* Sterile Petrolatum Gauze Dressings are so handy and so useful wherever an emollient, non-adherent, non-irritating, and non-macerating Covering, Packing, or Drainage material is indicated, for emergency or routine application. From compact foil-envelopes, they may be cut into strips or pads of various dimensions or folded, or used full-length. Fine-meshed absorbent gauze (44/36, Type I, U.S.P.) prevents growth of granulation tissue through gauze. The light, even impregnation with *sterile* petrolatum (white petroleum jelly U.S.P.) avoids danger of tissue maceration.

CHESEBROUGH MFG. CO., CONS'D
PROFESSIONAL PRODUCTS DIVISION
NEW YORK 4, N. Y.

Vaseline
Trade-Mark ®
Sterile Petrolatum Gauze Dressings

In Two Convenient Sizes:

No. 1 UNIT ENVELOPE — 3" x 36"
envelopes to the carton

No. 2 DUPLEX ENVELOPE — TWO 3" x 18"
6 envelopes to the carton

IN BURNS, WOUNDS, AND MANY SURGICAL PROCEDURES

more to install than do the all-electric units. This accounts for the rather wide range in prices of console air conditioners: between $500 and $900, installed.

If your office consists of two or three small rooms, you can air condition them in one of two ways: individual units in each room, or a large unit with connecting air ducts. The choice depends on the "heat load" to be carried.

Multiple-Room Units

Single self-contained air conditioners powerful enough for two to six rooms cost between $1,050 and $2,000, including installation.

In the long run a single unit may prove more economical than several small ones. It has the added merit of being adaptable to air heating during the cold months, and like the window units, it can be used for ventilation the year-round.

Now take an actual case: A G.P. in Ohio decided last month to air condition two rooms of his four-room office. The treatment room is 14′ x 14′ and has three windows with southern exposure. The reception room, measuring 22′ x 12′, is windowless and fairly cool; it's usually occupied by seven or eight patients.

Because he's in a medical building and hopes to have a home office in the future, this practitioner decided against an air conditioner requiring ducts. Instead, he got a large window unit ($410) for his treatment room and a medium-size console unit ($725) for his reception room. The total bill, including installation: $1135.

Operating costs are relatively low. Some of the factors in determining cost are temperature, size of room, number of people occupying it, amount of heat-conducting surface, presence of heat-making devices. The rock-bottom operating charge for the smallest window unit is about 15 cents for an eight-hour day. Of course, the price increases with the size of the equipment.

Many reputable manufacturers guarantee their refrigerating units for five years, the overall construction for one. But good equipment, serviced at regular intervals, should pay dividends in terms of greater comfort and efficiency for about ten years. END

Bundler

• About to enter the hospital for an operation, the patient was disgruntled to learn he had been assigned to a semi-private room. "It won't do at all," he announced angrily. "I never sleep two in a bed."

—R.N., NEW YORK

Lady out of the Dar

The selective cerebral action of Norodin is useful in dispelling the shadows of mild mental depression. The reported advantages of Norodin over chemically related analeptics include smaller dosages, more prompt and prolonged mental stimulation, and relatively few side effects. Norodin can be used to advantage in achieving the sense of well-being essential to effective patient management in functional and organic disturbances. In obesity, Norodin is useful in reducing the desire for food and counteracting the low spirits associated with the rigors of an enforced diet.

Supplied: 2.5 and 5 mg. tablets in bottles of 100

Norodin®

Hydrochloride

brand of methamphetamine hydrochloride

PSYCHOMOTOR STIMULANT AND ANTI-DEPRESSANT

Endo®

Endo Products Inc., Richmond Hill 18, N. Y.

Pressure mounts for . . .

More Local, Less Federal Taxing

. . . a sure key to less Federal medicine

● "To hell with socialized medicine," said a Texan at a medical gathering. "Let the self-supporting be taken care of through voluntary health insurance, the medically indigent through state and local subsidy."

"Sure," said another man present. "But what about the states and communities that *can't afford* adequate medical care for the poor?"

"They've *got* to afford it," was the answer. "If necessary, local government will have to collect more in taxes, the Federal Government less."

Easier said than done. The trend has long been in the opposite direction. In the last two decades, Washington's financial stranglehold on state and local governments has tightened rapidly. Thus:

¶ In 1932—just eighteen years ago—the Federal Government's cut of the tax dollar was 22 cents. Today it is 71 cents. State and local governments in 1932 got 78 cents of every tax dollar. Today they get 29 cents.

¶ From 1929 to 1948 the dollar total of Federal grants-in-aid rose 1,200 per cent. Today about 15 per cent of all funds spent by state governments comes from such Federal grants.

What's Needed

A number of organizations, boards, and commissions have looked into the problem during the last decade. They agree generally that (1) the level of government rendering a particular service should levy the tax and collect the revenue to provide for it, and (2) tax resources that can be tapped efficiently by local or state governments should be left to them, so that they can better provide for their own needs.

With each probe, demands for action have grown louder. They hit a crescendo last year, as the result of the Hoover Commission report and mounting state pressure. Congress was flooded with bills calling for a national commission to study Federal-state-local fiscal relations.

One such bill was reported recently to the Senate with twenty-

nine sponsors. Its prospects, however, are uncertain.

Latest move to halt galloping Federal taxes is one backed by fourteen anti-Fair Deal groups, including the AMA.* This powerful coalition, called the National Committee to Limit Federal Taxing Powers, urges a constitutional amendment limiting Federal taxes to 15 per cent of the national income.

$12 Billion Saved

Such a step would put the Federal budget at less than $30 billion for the coming year—$12 billion less than what President Truman is asking.

What's likely to happen if the brakes aren't soon applied? Experts in inter-governmental relations paint a gloomy picture. Here's one view as given jointly by the Council of State Governments, Governors' Conference, U.S. Conference of Mayors, National Association of County Officials, and National Association of Tax Administrators:

"[The] chain reaction is accelerating rapidly year by year: more demands upon local governments—more pressure upon the state governments to collect additional revenue and distribute it to the localities—hence even more pressure upon the National Government for grants-in-aid.

"If this trend continues . . . the states, because of increasing financial dependence upon the National Government, will tend inevitably to become administrative units in a national system, rather than constitutional entities within a federal structure."

States on the Dole

Another danger seen in the Government's tightening grip on public purse strings: Grants-in-aid will retard and repress the initiative of states. Those that avoid their responsibilities, it is argued are rewarded with Federal largess; those that accept their obligations get nothing.

Aside from the risk of over-cen-

*Others: Building Products Institute, National Association of Real Estate Boards, Committee for Constitutional Government, Conference of American Small Business Organizations, National Republican Roundup Committee, National Tax Equality Association, Southern States Industrial Council, Southern Pine Industry Committee, National Retail Dry Goods Association, National Retail Lumber Dealers Association, National Federation of Private Schools Association, American Retail Federation, National Association of Retail Grocers.

* HANDITIP *

Number Please

Neat solution to the pocket-notebook problem is a new scroll-type address and phone index called Listik. The thumb-sized metal case holds a ruled, plastic sheet that pulls down like a miniature window shade, springs back when released. Permanently erasable, it has space for 130 names, addresses, and phone numbers. Pencil is attached.

* * * * *

tralization of fiscal affairs, critics point out that many states are not getting a fair share of the national tax dollar. For example: According to Rep. Leslie C. Arends (R., Ill.), in 1948 the Federal Government collected more than $3½ billion from the people of Illinois, returned only about $280 million. "You simply cannot route your dollar to Washington and back home again without a great proportion of it being siphoned away," says Congressman Arends.

Blow to Socialism

But suppose state and local governments do succeed in getting a bigger slice of the national tax pie. What then? One result might well be a permanent damper on demands for socialized medicine. "Not one of the extensions of socialism could be put into effect without money," says Samuel Pettengill, former Indiana Congressman. "The number one plank in all platforms must be [to] reduce taxes and spending, especially at the Federal level."

Administration leaders, of course, have turned their backs on such proposals. They have made no move to pass taxing powers back to the states. Nor are they likely to, without a first-class battle. As things are shaping up, they may get one. END

"Well, we may not have found another wonder drug, but I bet the breweries will go for this!"

Diagnostic Services for Small Towns

Can your community set up and run one? Here's how others have turned the trick

• In horse-and-buggy days a doctor's bag was big enough to hold most of the diagnostic equipment he needed in general practice. Today a truck and trailer would scarcely fill the bill. Few physicians' offices are equipped with all the bulky, expensive gadgets science has dreamed up to help identify human ills. Usually only hospitals, and big-city hospitals at that, offer adequate diagnostic facilities.

Can low-cost diagnostic services be operated in small towns—on a basis satisfactory both to patients and private physicians? They can, says the W. K. Kellogg Foundation, and are—in twenty-four towns in the state of Michigan. Some of these communities, it reports, have as few as 10,000 people.

The Kellogg organization, which lent a helping hand with the projects, passes on some useful tips on how they were carried out. The question of location, for instance, was usually among the first to come up.

All the communities that had modern hospitals, says the foundation, elected to incorporate their diagnostic units into existing hospital plants. Towns without hospitals, but with near-future prospects, set up services in temporary quarters. Several areas had neither hospitals nor economic justification for building them. Yet successful X-ray-and-laboratory units were established, either in conjunction with health centers or under medical-society auspices.

Doctor Initiative

Who started the ball rolling? As a rule, says the foundation, hospital-staff members. Occasionally the trustees beat them to it; but the diagnostic services developed with the fewest hitches were those promoted from within the profession.

In either case, the hospital board usually appointed a preliminary-study committee manned both from its own membership and from the medical staff. Other community groups (Rotary, women's organizations, etc.) were represented if they had shown a particular interest in the idea.

This committee tackled five chief problems: (1) obtaining qualified personnel; (2) locating the service within the hospital; (3) selecting the equipment; (4) estimating the cost; (5) determining a method of financing.

The main personnel question was

Six Dietary Aids For You Who Treat FOOD-SENSITIVE PATIENTS

WHEAT-FREE DIET
EGG-FREE DIET
MILK-FREE DIET
WHEAT-EGG-MILK-FREE DIET
RESTRICTED (diagnostic) DIET
14-DAY FOOD DIARY

Prepared at your request . . . to fit your needs . . . to save your time when instructing patients . . . to make it easy for patients to follow the regimen you prescribe.

DIET SHEETS — Each includes: lists of allowed and forbidden foods; guide for selecting a nutritionally adequate diet; special recipes.

14-DAY FOOD DIARY—Supplies: spaces to record foods eaten; character of symptoms and times they occur; medications.

Each item above is available in pads of 50.
Send for booklet showing samples of each.

NO WHEAT — NO EGG — NO MILK

RY-KRISP contains only natural whole-grain rye, salt and water. Supplies all the protein, mineral and B-vitamin values of whole-rye grain . . . in crisp, delicious form.

USE COUPON TO SEND FOR **FREE** BOOKLET

Please send booklet C 2143, showing samples of above material, so I can order pads as needed.

RALSTON PURINA COMPANY,
Nutrition Service,
LE-H Checkerboard Square, St. Louis 2, Mo.

*Name*_____ *M.D.*

*Street*_____

*City*_____ *Zone*_____ *State*_____

how to obtain the services of a radiologist and a pathologist. Since populations of 40,000 and 80,000, respectively, are generally required to support these two types of specialist, none of the twenty-four communities could afford full-time men. Two solutions were found feasible:

In rural towns not too far from sizable cities, the hospitals contracted with urban practitioners for their part-time services. Hospitals of other towns clubbed together, sharing the cost and services of the needed physicians, with the latter dividing their time between two or more localities.

These part-time specialists were given full charge of their respective departments, X-ray and laboratory. They laid down procedures for record-keeping and preparation of reports, helped determine final selections of equipment, hired all technicians. The latter were specially-trained, full-time employes.

Where to locate the new diagnostic facilities was often the toughest poser. A first-floor site, close to both the hospital's main entrance and its emergency-case entrance, was usually considered best. Sometimes, in a pinch, the new department was put in the basement. In towns that had no hospitals, improvisation was carried to greater lengths. One Michigan community converted a barber shop into a diagnostic center. [*Turn the page*]

Clinic Operating Costs

(In a 25-Bed Hospital)

	X-Ray Dept.	*Laboratory*	*Total*
Consultants' fees	$ 3,411.48	$ 905.00	$ 4,316.48
Technician costs	1,561.03	1,462.74	3,023.77
Supplies & misc.	2,371.27	344.33	2,715.60
Total	$ 7,343.78	$ 2,712.07	$10,055.85

(In a 70-Bed Hospital)

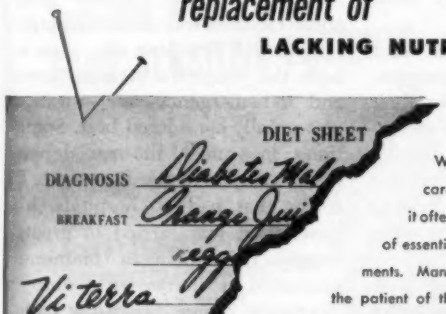
	X-Ray Dept.	*Laboratory*	*Total*
Consultants' fees	$ 4,571.94	$ 2,195.00	$ 6,766.94
Technician costs	5,401.21	5,394.35	10,795.56
Supplies & misc.	3,105.98	584.90	3,690.88
Total	$13,079.13	$ 8,174.25	$21,253.38

effective diabetes management demands . . .

Viterra

replacement of

LACKING NUTRITIVE ESSENTIALS



While the physician takes exacting care in selecting a diet for the Diabetic, it often fails to provide adequate amounts of essential vitamins, minerals and trace elements. Many elusive factors tend to deprive the patient of these important nutrients. Deficient soils, poor food processing, and faulty culinary preparation add to the deficiencies created by the dietary restrictions. Furthermore, recent discoveries have proven that many of the trace elements found in VITERRA definitely prolong the hypoglycemic action of insulin and, therefore, are important in the control of diabetes.

In planning the diet for the patient with diabetes mellitus, or any other conditions in which dietary restrictions are required, specify VITERRA.

● *12 Minerals and 9 Vitamins . . . all in one capsule*

MINERALS		VITAMINS	
Cobalt (*Cobaltous Sulf.*)	0.1 mg.	Vitamin A (*Refined Fish Liver Oil*)	5,000 USP Units
Copper (*Cupric Sulfate*)	1 mg.	Vitamin D (*Irradiated Ergosterol*)	500 USP Units
Boron (*Sodium Metaborate*)	0.2 mg.	Vitamin B_1 (*Thiamine Hydrochloride*)	3 mg.
Iron (*Ferrous Sulfate*)	10 mg.	Vitamin B_2 (*Riboflavin*)	3 mg.
Iodine (*Potassium Iodide*)	0.15 mg.	Vitamin B_6 (*Pyridoxine Hydrochloride*)	0.5 mg.
Calcium (*DiCalcium Phosphate*)	213 mg.	Niacinamide	25 mg.
Manganese (*Manganous Sulf.*)	1 mg.	Vitamin C (*Ascorbic Acid*)	50 mg.
Magnesium (*Magnesium Sulf.*)	6 mg.	Calcium Pantothenate (*Dextro*)	5 mg.
Molybdenum (*Sodium Molybdate*)	0.2 mg.	Mixed Tocopherols Type IV	5 mg.
Phosphorus (*DiCalcium Phosphate*)	165 mg.		
Potassium (*Potassium Sulf.*)	5 mg.		
Zinc (*Zinc Sulfate*)	1.2 mg.		

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Next step was usually to take inventory of the X-ray and laboratory equipment already existing in the area, including that in physicians' offices. Wherever the local profession was strongly behind the program, doctors were generally willing to refer complex diagnostic problems to the hospital, even if it meant disposing of some of their own equipment. In some hospitals, the laboratories were equipped to handle all tests; in others, provision was made to farm out some to larger hospitals.

Capital Needed

Initial cost of the twenty-four Michigan units varied widely. Of the twenty-one units established in hospitals, six involved no remodeling, one extensive remodeling. Average alteration expenses of the other fourteen: $1,170.

Most hospitals had some equipment that could be utilized or traded in. But had the start been made from scratch, the foundation estimates the minimum equipment cost for the smallest practicable diagnostic service would have been $8,400 for the X-ray department, $4,100 for the laboratory.

Operating costs are even more variable. In most cases, it's been found advantageous to pay the pathologist an annual retainer, fixed in advance. This consists of a flat fee (usually $300) for supervising the laboratory, plus a sum based on the number of tissues examined (at $3 each) and autopsies performed ($25 each) during the preceding year.

Several schemes are in use for paying radiologists—*e.g.*, fee per visit, fee per examination, percentage of departmental income. In one Michigan set-up, a radiologist serving three small hospitals gets an annual $4,000 or 25 per cent of gross (whichever is larger) from each institution. The specialist pays his own circuit-traveling expenses.

Over-all operating costs generally decline per unit of work handled as the service's total work volume increases. A breakdown of 1948 costs for a small and a medium-sized unit is given in the box on page 105.

Fee-Setting Techniques

Fees were customarily set in consultation with the pathologist and the radiologist, the county health officer and the medical society or full medical staff. Final approval

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was up to the hospital board.

"The preventive-medicine and public-health viewpoint should strongly influence the setting of fees," say the Kellogg people. "The cost of preparing and interpreting a chest film may, in some instances, exceed $2.50; and an X-ray examination of the lower intestinal tract may actually cost more than $12. But experience has shown that the number of such examinations called for in a given population group can multiply several times when the fees are reduced to such sums. People who would otherwise not be able to pay for these services get them, and the volume keeps unit costs to a minimum."

Final step of each planning committee was to draw up a budget covering both capital expenditures and operating costs. Possible deficits in the first year or two of operation were anticipated. The committee's final report generally included a survey of financing methods.

At this point the project usually passed into the hands of the community at large. The efforts of civic leaders were enlisted. Committee findings on the need for a diagnostic service were publicized. To raise funds, some towns resorted to contribution drives; others, to subscription techniques; still others, to appropriation of tax revenues. In subscription campaigns, many small gifts rather than a few large ones proved of most help.

—JOSEPH ROBINSON, M.D.

The Doctor Asks About the A-Bomb

Nine questions M.D.'s are posing about the medical aspects of an A-Bomb attack

● Five years after Hiroshima, medical knowledge in the atomic field is still sketchy. However, the minimum, local consequences of any future attack are now more or less predictable. One certainty: Physicians will be as busy as anybody. There'll be no time on A-day for questions and answers like these:

QUESTION: *What are the main causes of injury in an atomic explosion?*

ANSWER: (1) blast pressure, (2) flying debris, (3) flash burns, (4) nuclear radiation.

QUESTION: *What injuries offer the most immediate problem?*

ANSWER: Burns and mechanical injuries. Severe radiation symptoms don't usually appear until several days after exposure.

QUESTION: *How many severe burn cases can be expected from a single explosion?*

ANSWER: Based on experience at Hiroshima and Nagasaki—40,000 to 50,000. No estimates are available for the newer type bombs.

QUESTION: *Would bombs twice as powerful as those exploded in Japan cause twice as many injuries?*

ANSWER: No. A 100 per cent increase in explosive power causes a 25 per cent increase in the area of severe damage and injury.

QUESTION: *What medical supplies would be needed to treat severe burn cases?*

ANSWER: In one extreme case, a patient had to have forty-two tanks of oxygen, nearly three miles of gauze, thirty-six pints of plasma, forty pints of whole blood, and 100 pints of other fluids, plus such drugs as morphine and antibiotics. Three nurses were also required. Casualties in a catastrophe like Hiroshima would require a total of 250,000 pints of blood, at the rate of 80,000 a week for the first three weeks.

QUESTION: *What is the outline of treatment for nuclear radiation sickness?*

ANSWER: Whole blood transfusion, intravenous feeding, and control of bleeding and infection by use of drugs and antibiotics.

QUESTION: *How do rescue parties*

** Information given here was obtained from the National Security Resources Board.*

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*Goldthwait, J. E., Brown, L. Y., Swaim, L. T., and Kuhns, J. G., *Body Mechanics in Health and Disease*, 103-105, J. B. Lippincott Co., Philadelphia, 1937.

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entering bombed areas protect themselves against contamination?

ANSWER: By wearing filter masks; clothing that's tight at the wrists, ankles, and neck; and tight-wristed gloves. Bodies that have been exposed to radiation can be handled safely. But tongs should be used to lift radioactive objects in general.

QUESTION: *Are any courses being given in the treatment of radiological injuries?*

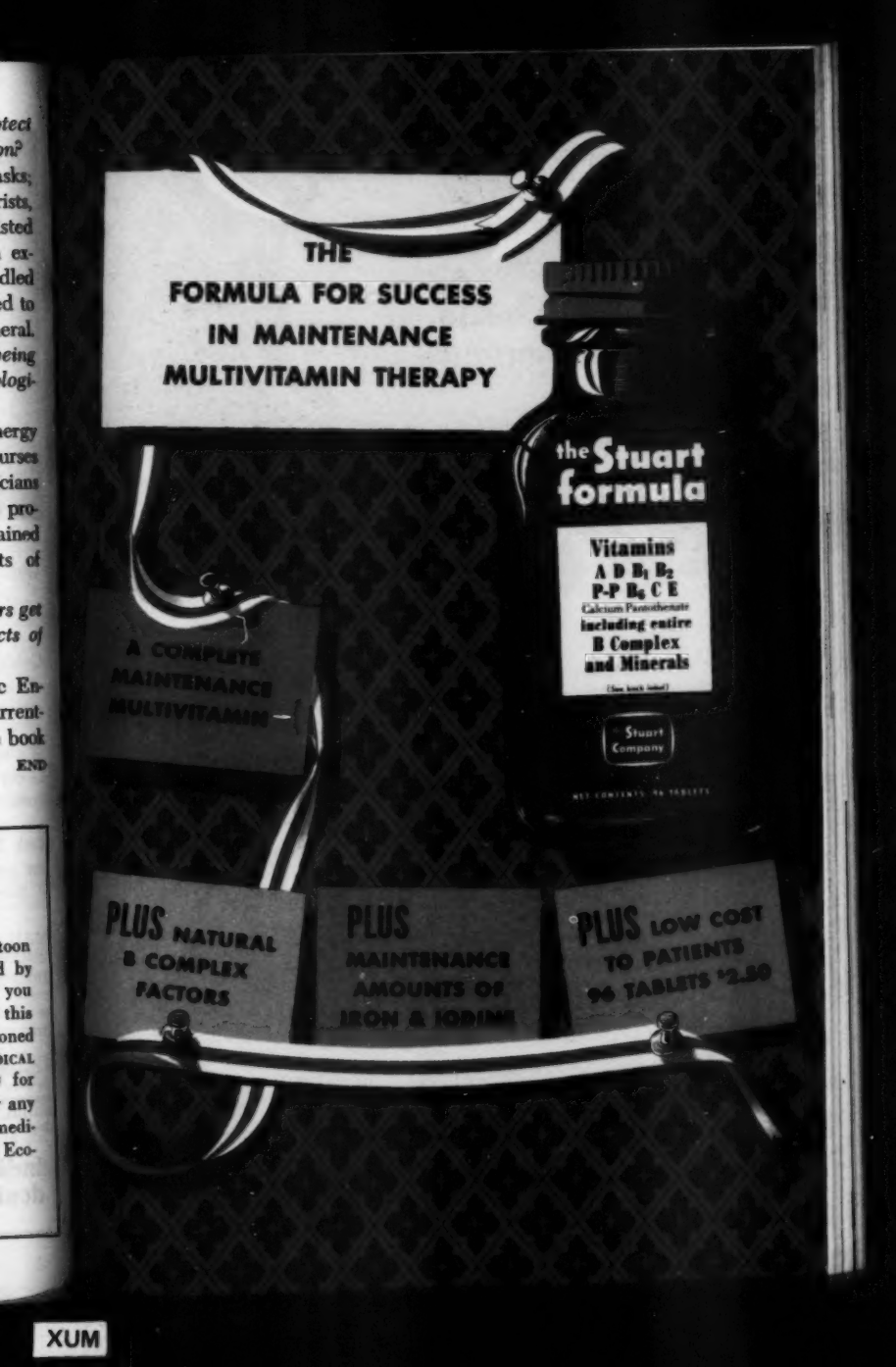
ANSWER: The Atomic Energy Commission is offering such courses to a limited number of physicians from each state. Purpose is to provide a nucleus of physicians trained to teach the medical aspects of atomic warfare.

QUESTION: *Where can doctors get a detailed report on the effects of atomic weapons?*

ANSWER: From the Atomic Energy Commission, which is currently preparing a comprehensive book on the subject. END

Cartoons

¶ The caption for the cartoon on page 127 was contributed by a practicing physician. Can you think of a gag line for this cartoon or for any other captioned cartoon in this issue? MEDICAL ECONOMICS will pay $10.00 for each caption accepted, or for any original cartoon idea with a medical slant. Address Medical Economics, Rutherford, N.J.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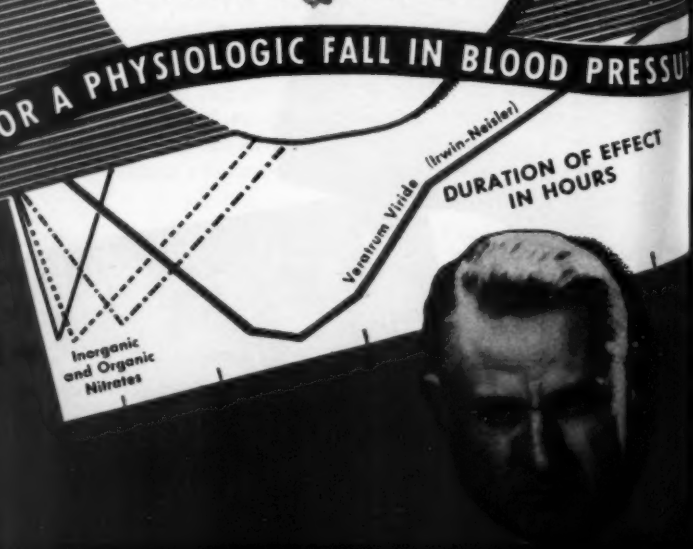


When you buy real estate . . .

Watch Those Building Restrictions!

• Some years ago a Missouri physician was haled into court by a neighbor who objected to the doctor's seeing patients at his home. The court ordered him to cease and desist.

Why?

The original owner of the land, subdividing it for development, had put certain restrictions into the parcel deeds. One stipulated the lots were for residence only—no "trade or business of any kind." The doctor didn't buy from the developer, but from a subsequent lot-holder. Too late he learned of the prohibitions on the land's use.

In court he came to grief despite conflicting testimony by real estate experts. Some argued that the practice of medicine in a residential section enhances the value of surrounding properties; others denied it. The point decided in this case was that a deed restriction against the use of premises for business purposes applies to, and thus rules out, the practice of medicine also.

Other courts have held likewise. A New York practitioner, for example, put up a house in a residential neighborhood, with one wing designed as an office. But his deed said the lot "shall be used exclusively for residential purposes, and shall never be used for any manufacture, trade or occupation."

No Practice at Home

Suit was brought and the court issued a permanent injunction to keep him from using the building for his professional office. A practitioner who sees patients at his house, it ruled, "thereby destroys the character of his home as a private dwelling, and it is no longer employed exclusively for residential purposes."

If the bars were once let down, reasoned the court, it would open the neighborhood to osteopaths, chiropractors, masseurs, and the like. Result would be an influx of

---

• *Bernard Tomson, who wrote this article is an attorney representing a number of architects, engineers, and contractors. He lectures frequently on real estate law, writes a monthly column ("It's the Law") for the magazine Progressive Architecture, and is author of a forthcoming book, "Law of Architecture, Engineering and Building."*

automobiles and a rash of signs on lawns and houses.

Deed limitations usually spring from a private developer's wish to make a real estate division more attractive to buyers. Other restraints on the use of property (e.g., zoning rules) are set up by municipal authorities. In many neighborhoods, for instance, an M.D. is allowed to carry on home practice only if his office is an integral part of his house. In Miami Beach, no physician can bring a patient near his home—except socially.

Hitches in the Law

Restrictions on his practice are not the only bugaboos that face the unwary doctor. If he's buying real estate as an investment, several other legal obstacles may upset him. Consider the man who recently built a ten-family apartment house in an area zoned for one-family dwellings. The town employes had known of the project from the start. But the court held that this was no excuse for violating the law.

Such details as the cost and size of the house, size of the lot, and location of the house on the lot may also be regulated by deeds and zoning laws. Not knowing about them can get you into a peck of trouble. For instance:

Suppose the owner of a two-acre plot sells you a piece 100 feet wide by 400 feet deep. You later find you must comply with certain building codes. One says the house cannot be placed closer than twenty-five feet to either side boundary. Another says that space on both sides of the building must total sixty-five feet. Whether you like it or not, you're stuck with a house thirty-five feet wide.

Even giving a deposit or signing a deposit agreement can get you into hot water. In many ways, putting your name on a contract of sale means more than the actual closing of title (when the deed changes hands). This is because the conditions under which the deed is delivered are largely fixed by the terms stated in the sales contract.

So look into all angles *before* you sign any papers or checks. Better

yet, stay away from that dotted line till you've had a lawyer and an architect examine the small type above it—and the building code provisions of the community.

—BERNARD TOMSON, LL.B.

The Granny Racket*

A reply to Harold Stassen by a noted apologist for the British health scheme

• If we look at the world of today with the detachment of a visitor from another planet we see reorganization everywhere—not only in the state, but in big business, in big industry. Where change is most rapid and most radical, there it is most necessary that its progress be helped and its direction guided scientifically.

The road of scientific advance is marked by milestones on which are inscribed the names of men of genius; but the man of genius can do no more than find the key that fits the lock of a new door. To turn that key, to push open that door, to explore the passages to which it leads, he needs help. He needs thousands of workers to get details settled and millions of money to provide the apparatus for mass research. Only very wealthy bodies can provide that help. The really vital question is not whether the state takes part in the future development of a medical service, but, if and when it does so, what part it will take.

This question confronts the American medical profession today. The more courageous among them realize that now, while the sun of prosperity still shines, they have a unique opportunity to plan a health service along lines of their own

---

* *Mr. Stassen's articles in the Reader's Digest about Britain's National Health Service had reached so many people all over the world that advocates of the service felt obliged to say something in its defense. Their rebuttal appeared as the lead article in the British Medical Journal a month ago. It bore the above title and was signed by Sir Heneage Ogilvie,* M.D., M.CH., *surgeon to Guy's Hospital, London.*

For reasons of conviction or expediency, the leaders of the British Medical Association, Sir Heneage among them, have seen fit to give the health service their official support. This, despite the fact that a broad cross-section of British doctors interviewed by MEDICAL ECONOMICS *found more in the service to damn than to praise.*

Sir Heneage's remarks, slightly condensed, begin on this page.

choosing, to work with their Government as partners rather than as servants, to extend their research on national lines to unimagined goals.

'Go to Sleep'

Others, like Gallio, care for none of these things, but shut their eyes to the facts around them. Such men find Harold Stassen's articles in the Reader's Digest, which many of us have read with amusement, meat and drink. "Never, Never, Never," in January, is a study of the British health service based on interviews with discontented doctors and on a few slightly inaccurate figures. "Granny is Gone," in the February number, tells the story of the old lady who died of pneumonia because she could not be found a bed under the National Health Service. Both articles pay little more than lip service to veracity, but they encourage the American reader to thank God he is not as other men are, and to turn over again and go to sleep (Matthew, vii, 3).

The facts are these:

The large American hospitals which are not state-owned or limited to paying patients are "in the red." They are facing a loss that increases every year, and they are increasingly worried over it.

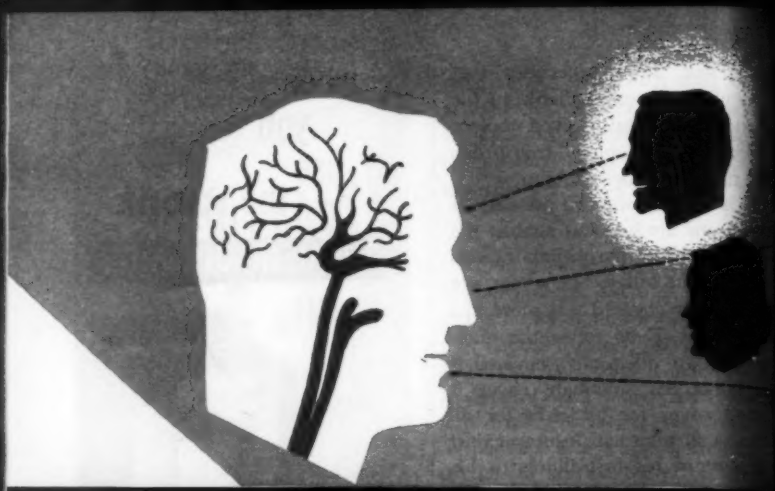
The poor American is worse off than Granny, for he gets very little unless he pays for it. He cannot get a nurse to look after him at home, as Granny could have done at the Government's expense. He has

never had those necessities that have always been available to the poorest in Britain, even before 1948: unlimited blood transfusion and unlimited chemotherapy.

It is claimed that 50 per cent of Americans are covered against the cost of sickness by insurance. This may be true today, but a year ago the number covered was more like 5 per cent. Even today the number who are *adequately* covered is negligible. By adequate cover is meant cover for all risks for all time. A fit man can insure against the cost of his first illness or his first operation for a reasonable sum. Once he has been in a hospital he can reinsure only at a considerably enhanced premium, or with the more probable risks excluded. When he is really ill he is uninsurable. It is claimed also that those who are so insured can get the best that American medicine has to offer: unfortunately they may easily get the worst.

Boom in Bile Ducts

American research leads the world. The best American hospitals and the best American physicians and surgeons are very good indeed. They give service second to none in the world. But there are also a number of doubtful clinics hungry for customers, and a host of untrained specialists and fake consultants hovering on the outskirts and ready to prey on any sick man who strays from the fold. Many men who would not pass scrutiny as specialists have admitting rights



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Griffith and Lindauer,* in a study of 1200 hypertensives found capillary abnormality in some 30%. Moreover, in this group the risk of vascular accident was increased fivefold!

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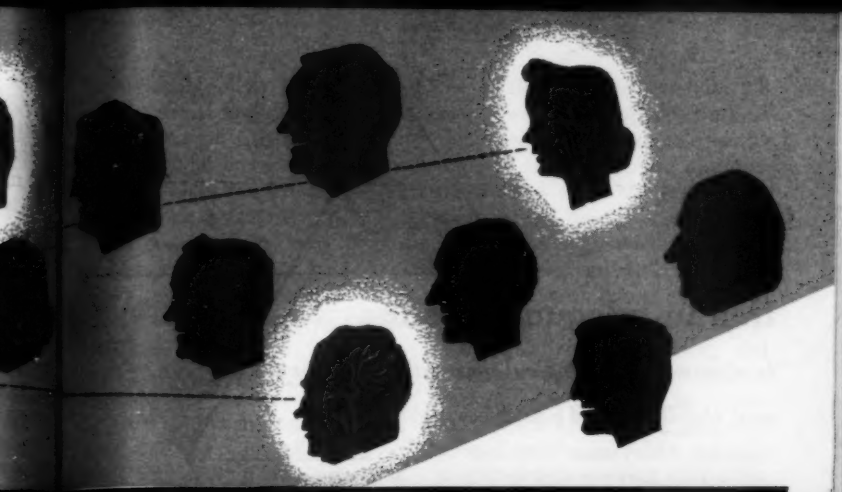
*Griffith, J. Q. and Lindauer, M. A.: Ohio State M. J. 43:1136 (1947).



lar accident in hypertension

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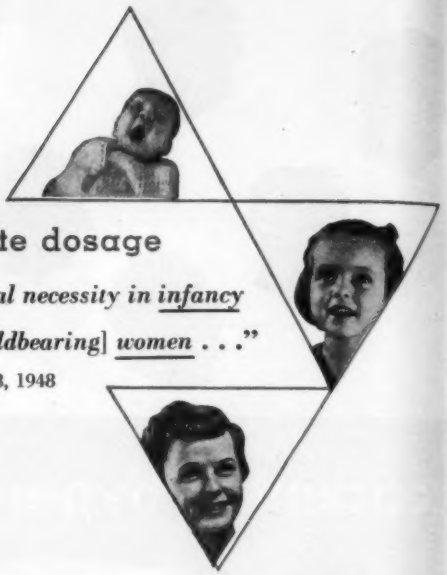

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"is almost a physiological necessity in infancy and childhood and [childbearing] women . . ."

Sundaram, S.K.: Lancet. 1:568, 1948

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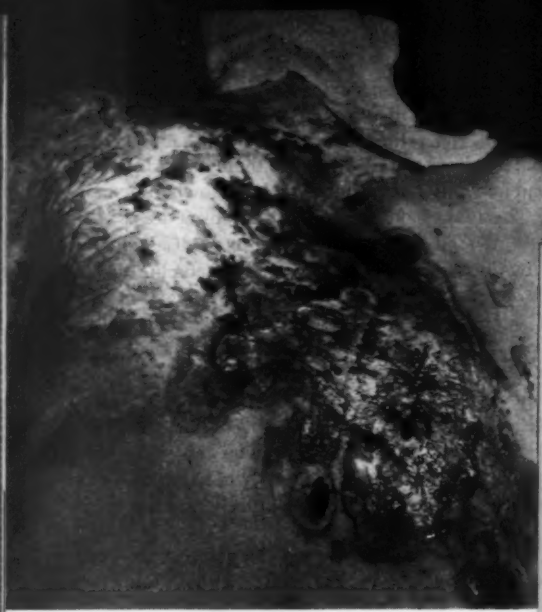
to the best hospitals. It is only necessary to read books like *Petticoat Surgeon* to get a glimpse of the chicanery and commercial dealing to which the sick American may fall a prey if he is unlucky. The number of common bile ducts divided in America every year by incompetent surgeons exceeds those so injured in Britain by a significant margin.

Of all branches of science, medicine concerns the state most closely, for it affects the health, happiness, and working efficiency of every one of the human units that make the state. It is to the state's own interest to ensure that every citizen, however poor, shall find available to him the best treatment that modern medicine can offer. All men would agree on the truth of these two propositions; it is in the application of them that disagreement is inevitable. Nowhere is help more needed than in medicine; nowhere is control more disastrous.

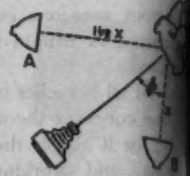
Fifty years ago medicine was a bedside science. Investigation was limited to clinical methods, diagnosis was largely empirical, and treatment took the form of shotgun prescriptions couched in Latin. Fifty years ago surgery was conducted on wooden tables by men in shirt-sleeves working with a few simple tools and relying on antisepsis for safety.

Today we do not rest until we have an exact diagnosis, and we

"Me and my big mouth! His nurse, I found out, is also his wife."



ABOVE: *Blastomycosis, with heavy skin involvement.* BELOW: *Control of infection after treatment.*



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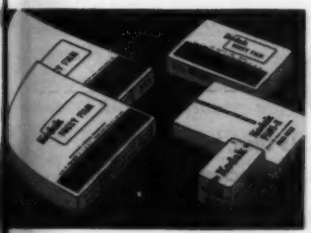

X-ray film, screens, and chemicals; electrocardiographic papers and film; cameras and projectors—still- and motion-picture; photographic film—full-color and black-and-white (including infrared); photographic papers; photographic processing chemicals; microfilming equipment and microfilm.

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depend on a host of accessory methods—radiological, electro-optical, bacteriological, and biochemical—to reach that exactitude. Having made our diagnosis, we rely on single drugs, usually produced by a long chain of synthesis from some simple ancestor, and chosen to produce some exact effect on the body or its invaders. A surgical operation requires surroundings and instruments of great complexity, and the services of specialists in many branches collaborating from the time when it is planned till many weeks after it is over.

More Beds per Man

The high standards demanded by modern medicine and surgery can be reached only in a hospital, and, as more diseases become amendable to treatment, the number of hospital beds needed for any unit of population increases. Hospitals are growing in numbers, in size, in complexity, and in the cost of their construction and maintenance.

The time when wealthy philanthropists were able to found and maintain institutions is past. The time when doctors or patients could afford the costly drugs that may be needed for the treatment of a case is equally behind us. The support of hospitals and the maintenance of research must in future fall upon the largest kind of corporate body, either professional or state.

What alternatives are there? Insurance? We have to admit that insurance, with all its past successes, appeals to the business rather than to the charitable instincts of a nation.

Needed: More Purview

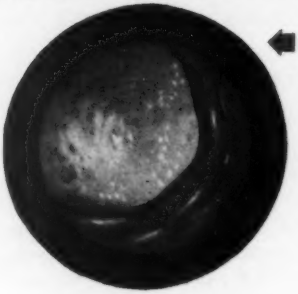
While men are willing to share the cost of providing against a probable risk with others of the same profession, trade, factory, or income group, they are not as eager to finance those outside the group, such as the destitute and the aged, or to insure against risks that are not their immediate concern, such as the exploration of the radioactive substances or research into the causes of cancer. Here in fact only a body of the widest purview will be ready to take action on a scale sufficiently bold.

Such a body, either professional or state, must have great resources and great powers—above all, a great organization. And all such organizations have those defects which we describe as bureaucratic. If the state finds the money, it tends to interfere in the spending; at the least, it wants to be assured by its own experts that it is getting value for its money. But it is apt to set its own definitions on value and on what is an expert.

The Laboratory Animal

Many methods of organization are under trial. They are all undergoing modification and, we hope, improvement. The American medical profession has the unique advantage of being able to study these

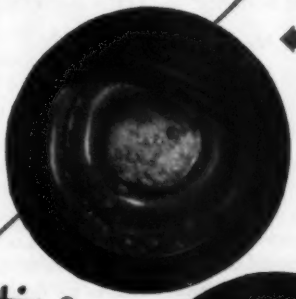
THE CASE OF MR. W. S.



HUGE CRATER ULCER
Revealed by
Gastroscopic Examination

THERAPY: Medical Management with **MUCOTIN**

GASTROSCOPIC PROOF OF HEALING



4 WEEKS LATER

Ulcer definitely smaller showing continuous healing.

5 MONTHS LATER

Crater gone.
Ulcer healed.
No recurrence.

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MUCIN MAKES THE DIFFERENCE

Each tablet contains: Purified gastric mucin . . . 0.16 gm. Dried aluminum hydroxide gel. . . . 0.25 gm. Magnesium trisilicate . . . 0.45 gm.

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human experiments in progress (if they *will* study them) without suffering the pangs of the laboratory animal, of being able to learn what is good and what should be avoided.

What is good in our system is apparent: that the expense of medical care, education, and research will in the future be provided from public funds. What is unsatisfactory is equally apparent: the waste of money on unnecessary transport, on expensive apparatus that is not wanted and not cared for, on the administrative hordes that have settled on the body of British medicine and are costing more than the care of the sick.

Only Bogeymen

What is bad is as yet feared rather than apparent, and, given wisdom and a willingness to amend abuses as they appear on the part of successive Ministers, it may never happen. The disaster that is greatly to be feared in any state medical service is the loss of freedom—freedom for the doctor to follow truth where it leads him, freedom for the patient to seek help where he has confidence. For the preservation of this freedom two things are essential: first, that all purely professional matters concerning medical education, the staffing of hospitals, and methods of treatment shall be decided on the advice of professional bodies chosen not by the Ministry but by the profession themselves; and, second, that private practice must continue.

One of the most unfortunate things about the inception of a medical service is that it imposes a rigid and artificial system of grading. Grading is inevitable in medicine, but just as in boxing or lawn tennis a man's grading is that which he makes for himself, so in medicine a doctor's grading is the position he attains in the eyes of his fellows and his patients. Academic training, degrees, honours, appointments, publications, all these things count, but they count little beside that indefinable quality: a man's real worth.

The State's Choice

Where a state department picks its experts on the results of an interview or on the advice of a select committee it nearly always picks the wrong men. The danger of of-

* HANDITIP *

Key Cue

To eliminate fumbling in the dark for the right key, I've devised a touch system of identification—notches filed on the back of each key. For example, one notch tells me it's my front-door key; two, my garage key; three, my office key; and so on. A big help when coming back from a late evening call.

—W. F. SCHAPHORST

ficial interference in matters of treatment needs only to be stated to be apparent. The orthodoxy of today is the heterodoxy of yesterday, and may be the discarded fallacy of tomorrow. Methods, like men, must establish their own grading.

On, Private Practice!

Above all things it is important that the relation of confidence between the doctor and his patient should not be disturbed. The patient should look on his doctor as a man of power who can invoke state assistance and command state resources, never as an official at the end of an office string. For this relationship to be maintained, it is essential that private practice be encouraged rather than driven into the hands of the small group of charlatans who would still exist to prey on the stragglers of a society in which all reputable doctors were perforce full-time employes of the state.

In matters of decisive concern to the individual—his health, his house, his legal affairs, his money—each man should be free, if he so desires, to seek advice from an expert of acknowledged position and integrity, an authority chosen by himself.

Only when such a body of experts is available, as a standard for comparison and as a court of appeal, can a government service be wholly efficient or command complete confidence.

Dragged Down the Path

American medicine is at the crossroads, and American doctors would be wise to face that fact. They can see, if they will look, other nations proceeding along, or being dragged along, some of the many paths that lead from the crossing. They are still free to choose their own. They can pick the good and reject the bad from other systems if they will study them, and from these pickings they have today an unparalleled opportunity, one that will never come again, to produce their own system and make it work.

They can then go to their Government and say, "Here is a plan that we, the doctors of America, have devised and tested. We claim

6 Reasons Why OCTOFEN® is the Drug of Choice in Treating ATHLETE'S FOOT!

Out of scores of clinical tests come 6 excellent reasons why **Octofen** is the drug of choice in treating athlete's foot:

1. Kills fungi on contact.
2. Has been shown to clear up athlete's foot in as short a time as 1 week.
3. Has shown no primary irritation or sensitization in clinical work to date.
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5. Free from irritants, heavy metals, tars, oils, phenols or alkalies.
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½ and 4 Ounce Bottles for your In Convenience.

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For truly fungicidal results—
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Please send me **Free** four 1-oz. sample packages of **Octofen**—sufficient to test its efficacy—and descriptive literature.

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"... nontoxic physiologic..."

For eye infections—

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PROPION®

Ophthalmic

5% sodium propionate (w/v) in neutral solution

From a recent clinical report* on treatment of about 400 cases of conjunctivitis, blepharitis, and keratitis:

"... (in acute infection) sodium propionate appears efficacious in about as short an interval as any other drug used and seems to have no unpleasant sequelae ... It has proved efficacious and nonirritating, especially in chronic conditions..."

*Theodore, F.H.: Arch. Ophth. 41:83, 1949.

Solution Propion Ophthalmic. Bottles of 5 fl. dr.

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that it will keep our scientific research in the forefront of world progress, that it will allow every man who enters medicine to find that work to which he is most suited by inclination and ability, and that it will enable every citizen of our great country to get the treatment that his disability demands. We can prove that the cost of this system to the country is less than that of the National Health Service in Great Britain, that the benefits it confers are greater, and that it is more readily adaptable to changing needs. We ask you to take it over as a going concern. We will run it for you."

The organization of medical services must come, all over the world, and the best people to initiate and develop such a public service are the doctors themselves. They alone have a clear grasp of the true relation of those services to the people, which is essentially that of servant and master—meaning that the true centre of interest and action is not in the authority but in the patient. And that patient is not a number in an office, but a unique person, a living soul. It is because doctors—and especially that most responsible of doctors, the general practitioner—can never forget that all-important fact, so easily mislaid in offices and ignored by governments, that I hope the American profession itself will take the first steps in its own development on a nation-wide scale. Will it do this? Not if it goes on worrying over Granny. END

Research Group Analyzes Health Facts

• How can more people get better medical care for less money? How many doctors are needed? How many hospitals? The Health Information Foundation, launched in February, is now busily piecing together answers to these and other urgent questions. Says Admiral William H. P. Blandy, HIF president: "We're developing a pattern by which a community can evaluate its own health facilities and correct any deficiencies."

Currently under way is a nation-wide study of medical services. By cataloguing everything from diagnostic clinics to drugstores, the foundation seeks to spot marginal areas where health facilities are below par. [*Continued on* 149]

Is There a Future In General Practice?

One Man's Opinion

● The question above is heard more often today than ever before. Yet it's out of date. It's *passe*.

Why? Because the answer, for those who will seek it out, is now perfectly clear:

There *is* a future in general practice—a shining future!

The trend toward specialism reached its peak at least two years ago. A new trend has supplanted it. The inevitable result of this will be to recognize and dignify general practice as the backbone of the *corpus medica*. The specialties can never be more than its extremities.

For years the fashionable view has been that the G.P. is little more than the specialist's water boy. The fact is that the G.P. never has been—and never will be—anybody's water boy.

People have been led to believe that the medical man who concentrates on the whole body is inferior to the man who concentrates on a part of the body. To me that's like saying the five-letter athlete is inferior to the gridiron star who has only one letter.

So unbridled has been the expansion of specialism that several branches of medicine now threaten to break off and float into space as independent planets. More than ever, therefore, we need the medical coordinator—the G.P.—to interpret each specialty in its relation to the others.

If the G.P. assumes his rightful place, it will be

fast disintegration

fast action

fast relief

"Exorbin," one of the latest advances in antacid therapy, provides all of these advantages. "Exorbin" is an anion exchange resin which adsorbs hydrochloric acid from gastric juice.

Reaction in the stomach: $RX+HCl \rightarrow RX.HCl$

RX = anion exchange resin with the acid binding substituent X

When the resin and the attached acid molecules reach the alkaline medium of the intestine, the acid is released and neutralized; the resin is then excreted in its original form.

Reaction in the intestine:

$2RX.HCl+Na_2CO_3 \rightarrow 2RX+2NaCl+H_2O+CO_2$

No interference with normal bowel function[1]
No alteration of acid-base balance of body fluids[2]
No toxicity even with massive dosages[3]

[1]Kraemer, M.: Postgrad. Med. 2:431 (Dec.) 1947.
[2]Kraemer, M., and Siegel, L. H.: Arch. Surg. 56:318 (Mar.) 1948.
[3]Martin, G. J., and Wilkinson, J.: Gastroenterology 6:315 (Apr.) 1946.

"Exorbin" No. 373 is presented in tablets of 0.25 Gm. (4 grains); bottles of 100. Also available in Powders, 1 Gm. (15 grains), No. 372; boxes of 50.

"Exorbin" brand of Polyamine Resin

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he who keeps the neurologists and pathologists, for example, on speaking terms. It will be he who steers the patient through the maze of specialties and subspecialties. It will be he who keeps medicine from becoming fifteen or sixteen separate sciences, each increasingly independent of the others.

The G.P. should be, and is, the man who can tie the specialties together, who can prevent specialties from forgetting that the human body and mind are one unit and not so many discrete pieces.

I'm reminded of a woman I know who shopped among our local specialists for several years, trying to locate her trouble by process of elimination. She went to a gynecologist, a chest man, an internist, a goiter specialist, and a gastroenterologist. Finally she consulted me on what kind of specialist to see next. I asked who her family physician was. She had none. What she needed was a medical counsellor, a guide, to take her in hand.

"The most immediate result of our unbalanced specialization," says the Spanish thinker, Ortega y Gasset, "has been that today, when there are more scientists than ever, there are far fewer 'cultured' men than, for example, in 1750." But the renascence of the "cultured" man of medicine—the G.P.—is now under way. Special societies are being formed for training G.P.'s in the newer techniques. Those who meet certain standards may get recognition through a system of certification. Hospitals are reorganizing their staffs, giving general practice a division of its own, equal in rank with the specialties.

Of course, it's up to the G.P. to keep within the limits of his postgraduate training and experience. But no one should have a prior right to take patients to a hospital or to treat them there.

No degree outranks a straight M.D. No one can obtain a higher official license to practice medicine than the one that hangs in every G.P.'s office. The G.P. can be proud he's a doctor who never has to say helplessly, "I don't treat that."

Any future in general practice? Why, that's where the future *lies*.

—AS TOLD TO FRED DE ARMOND

No Charge, Son

• As an Army medical officer in the Phillippines, I was called to see the aged and dying father of a native storekeeper. Several weeks later, I met the son on the street. He said to me: "Doctor, that time you come kill my father—how much I owe you?"

—CLARENCE E. FRONK, M.D.

ABC's of Office Wiring

Some non-technical pointers that will help keep you out of electrical trouble

• "This is Dr. Harper calling—from the Harper Clinic. What's the matter with the wiring job you did here?" he asks the electrician. "Every time we plug in a piece of equipment a fuse blows."

A quick check by the serviceman uncovers the trouble: In drawing up the wiring system, he located special outlets where heavy-duty electrical equipment was to be used. Later the clinic doctors did some rearranging. The fireworks started when sterilizers were plugged into outlets designed for lamps.

• • •

You don't have to be an Einstein to avoid this kind of mishap. A few basic facts (plus a good electrician) are pretty fair insurance.

If you're planning a new office, don't scrimp on wiring. It's much cheaper to provide for future growth than to add or replace wiring later. The cost of an electrical system averages about 6 per cent of the total building cost. So even a 20 per cent saving on wiring cuts your over-all bill little more than 1 per cent.

Expect to install an X-ray machine later? Then make advance provision. Unless it's a portable unit, be sure you put in a heavy enough power line from the street. You'll also need a special circuit from your fuse box to the wall outlet. An X-ray manufacturer will give you specifications for the type of machine you need.

When You Rent

Suppose you're going to rent office space. If you have to bring in a special outside line for X-ray, get an electrician's estimate before you sign a lease. It may cost you anywhere from $25 to $150, depending on the length of line needed. For upper floors, the cost increases as you go up.

When planning to rewire an office you're renting, see that the lease states clearly (1) what alterations you're allowed to make; (2) who will pay for them; and (3) whether you can take your installations with you when you move.

Most rural areas now have power service adequate for X-ray equipment. But it's wise to check before you buy or rent. A few metropolitan areas still use direct current,

Are YOU interested in a preparation which has benefited 85.1% of 3634 Arthritic Patients?

● Recently 36 physicians reported to us their results with RAY-FORMOSIL, treating 3634 arthritic patients' over a 2-year period. 85.1% were benefited.

Number of Cases Treated (by Type)		Number of Cases Benefited	Percentage of Cases Benefited
HYPERTROPHIC	1906	1663	87.3%
INFECTIOUS	486	392	80.7%
RHEUMATOID	1146	958	83.6%
FIBROSITIS	96	79	82.3%
TOTAL	3634	3092	85.1%

These strikingly favorable results confirm the value of administering RAY-FORMOSIL ampuls in treating rheumatism and arthritis. No untoward effects were reported in any of these cases—RAY-FORMOSIL is virtually non-toxic in its recommended dosages. During the past 15 years, more than one million RAY-FORMOSIL ampuls have been administered.

FORMULA: Each cc. contains:
Formic Acid..... 5 mg.
Hydrated Silicic Acid..2.25 mg.

SUPPLIED: Two cc. ampuls: boxes of 25 ($7.50), 50 ($14.00) and 100 ($25.00).

These net prices to physicians are 25% off regular list prices.

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OVER A QUARTER CENTURY SERVING THE PHYSICIAN

PHARMACAL COMPANY

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N. E. CORNER JASPER AND WILLARD STREETS
PHILADELPHIA 34, PA.

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COUNCIL ON PHARMACY AND CHEMISTRY

- + Relieves symptoms — quickly and thoroughly.
- + Cardiovascular and psychic symptoms relieved.
- + Economical.

Dosage: Initial therapy 1 (1 mg.) tablet t.i.d. after meals; maintenance therapy, 1 to 2 tablets daily.

Packaging: 30, 100, 500 and 1000.

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- — Tasteless
- — Odorless
- — Unpleasant reactions— virtually unknown.

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ELIXIR PEPTENZYME

is compatible with most drugs—

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Simplify Prescription Writing

The amazing versatility of ELIXIR PEPTENZYME—its effectiveness in disguising the taste and odor of unpleasant drugs, its compatibility with almost all commonly used drugs and its exceptional dissolving properties, has commended the preparation to physicians for over 60 years.

ELIXIR PEPTENZYME contains 16 carefully selected aromatics and 3 solvents. It is one of the most widely used pharmaceuticals.

Simplify the writing of prescriptions that appeal to your patient's palate: ELIXIR PEPTENZYME is synonymous with "good taste in medicine."

Packaging: 8 oz., 16 oz., 5 pts., and 1 gal.

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and most electrical equipment, including larger X-ray units, is wired for alternating current. To adapt them to DC you need a rotary converter, an expensive solution.

How about a sterilizer? Some models operate off a standard, branch circuit. But the larger types (more than 20 amperes) require special wiring. Most of your other electrical equipment can be plugged into ordinary outlets. But it's a good idea to draw up a list of these units and where you'll use them. Then your electrician can design proper circuits to carry them.

Ever notice a marked dimming of lights when you plug in an appliance? That's a sign of overloaded wiring. It results in waste of electricity, poor performance of equipment, and blown fuses. It's also a fire hazard. Chances are you need one or two more circuits to divide the burden.

An overloaded circuit isn't the only reason fuses pop. Sometimes the line is not fused up to its capacity. But don't take it upon yourself to use higher-amperage fuses. Let your electrician decide.

Though you may not be having trouble now, keep extra fuses on hand. And map out a system for replacing them quickly in an emergency.

One method: Number small bits of adhesive tape, stick one next to each fuse socket. Then key these numbers to a list of fixtures and outlets. Paste this list on the inside of the fuse-box door.

If you're building, you may want to install circuit breakers. These electrical trouble-shooters do the work of fuses but require no re-

"Does this pharmaceutical you recommend carry the endorsement of the Council on Pharmacy and Chemistry?"

AMERICAN "D.P.'s"

Not displaced but deficient describes these Americans, no matter what their economic status may be. These persons are deficient because they are drained and depleted of the most important but transitory of vitamins—the B Complex—by food foibles, fever, surgery and chronic disease, even to the extent of aggravating basic hormonal imbalance in diabetes and hyperestrogenism.

Efficient utilization of any of the many interrelated factors of the B Complex is often dependent on the presence of the others. *Inadequate B Complex therapy in these patients often prolongs recovery.*

THAT is the reason Provite 'B' contains therapeutic concentrations of the important B Complex factors (whose value has been clinically established) plus all the B Complex factors naturally present in liver and yeast.

Each Capsule Supplies:

Thiamin HCl	25 mg.
Riboflavin	12.5 mg.
Pyridoxine HCl	1.5 mg.
Calcium Pantothenate	5 mg.
Niacinamide	150 mg.
Choline Dihydrogen Citrate	100 mg.
Inositol	50 mg.
Secondary Liver Fraction	Q.S.
Yeast, Dried	Q.S.

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In bottles of 100 and 1,000 capsules

placements. When the current gets too great, the breaker controlling the circuit is tripped and the circuit is opened.

To restore the power, you simply push a small lever. Since the circuit breaker has a set rating, there's no risk of fire through over-fusing. Initial cost, installed in the average home, is a little less than $50, or about three times that of a fuse box.

But even adequate wiring serves little purpose unless outlets are where you need them. So:

¶ A good rule of thumb is—at least one outlet for each ten to twelve feet of wall unbroken by a doorway, and at least one in each broken wall space three feet or more in length.

In your reception room, have duplex plug-ins placed close to each furniture grouping. Lamps and appliances should be no more than six feet from the nearest outlet. Otherwise patients may trip over the wires.

¶ Where possible, wire half the outlets in a room on one circuit, the other half on another. Then if one circuit goes dead, only half the outlets will be affected.

Each outlet for heavy-duty equipment should be on a circuit of its own. Probably one or two such outlets will do for the average treatment room. They should be of the three-wire variety—i.e., able to take an instrument equipped with either a standard two-wire or a three-wire cord.

An electrical machine with a three-wire cord has this advantage: If a bare wire happens to come in contact with the instrument case, there's little chance of your patient getting a shock, since the instrument case is grounded through the third wire. END

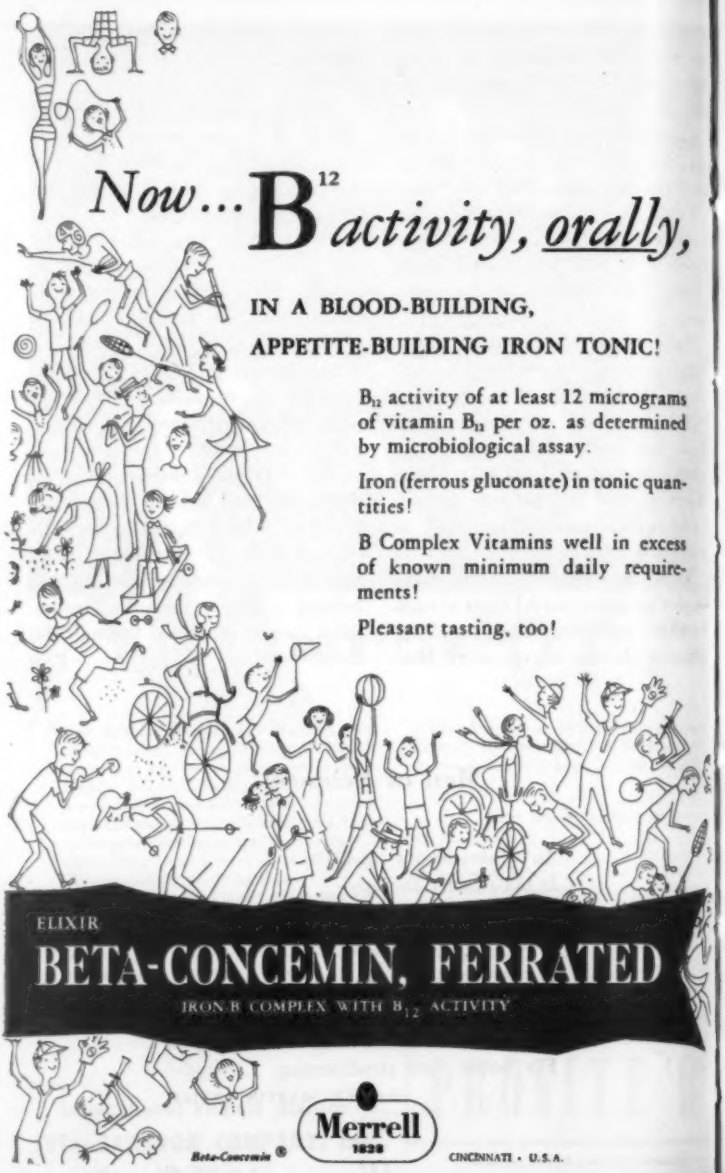
Men of Science

I

An obstetrician's specialty
Is not exactly therapy—
Nor prophylaxis. His concern
Is population's upward turn.

He emulates the stork in flight
And often works both day and night,
All the while petitioning
For better heir conditioning.

—ALICE MARTIN LESTER



Now... B^{12} activity, orally,

IN A BLOOD-BUILDING,
APPETITE-BUILDING IRON TONIC!

B_{12} activity of at least 12 micrograms of vitamin B_{12} per oz. as determined by microbiological assay.

Iron (ferrous gluconate) in tonic quantities!

B Complex Vitamins well in excess of known minimum daily requirements!

Pleasant tasting, too!

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BETA-CONCEMIN, FERRATED

IRON-B COMPLEX WITH B_{12} ACTIVITY

Beta-Concemin ®

Merrell
1828

CINCINNATI • U.S.A.

Research Group Analyzes Health Facts

[*Continued from* 137]

With the groundwork laid, the HIF will then make pilot surveys in such typical communities as Columbus, Ohio. These surveys will point the way to the basic health pattern that HIF is trying to find.

But HIF won't carry the ball alone. It will encourage local citizens to pitch in too. Says Admiral Blandy: "Only by analyzing their own problems can they educate themselves and their neighbors."

Credit for organizing the HIF goes to leaders of the drug, pharmaceutical, and allied industries. Months ago they put their fingers on the basic obstacle to improving the nation's health: Although scores of agencies were at work on isolated parts of the problem, their findings had never been integrated. Industry's solution: a clearinghouse of facts.

No Lobbying

Facts are, indeed, the foundation's reason for being. Its charter prohibits "lobbying and propaganda activities." Says John G. Searle, HIF board chairman and president of G.D. Searle & Co.: "Our approach is entirely positive and constructive."

Two of the positive goals the foundation has set for itself are:

¶ Expanded medical services under local control.

¶ Bigger and better voluntary health insurance.

Key men in the set-up are Admiral Blandy and his executive secretary, Kenneth Williamson Before his retirement from the Navy early this year, Admiral Blandy was Commander in Chief of the Atlantic Fleet. Mr. Williamson was assistant director of the American Hospital Association. Others on the HIF staff are a research analyst and the assistants who do leg work.

The Lay Viewpoint

A citizens advisory committee under the chairmanship of Herbert Hoover provides the layman's viewpoint on health problems. Other committees give professional and technical advice in analyzing health facts.

Chances are that the HIF won't need much more personnel. Most of the facts it uses have already been gathered by other agencies. Typical sources: American Medical Association, Public Health Service, Brookings Institution.

When the Health Information Foundation will announce results is hard to forecast. Best guess is that its major projects may take two years. As far as most doctors are concerned, they can't be completed soon enough. For, in the battle against Federalized medicine, every round of ammunition is needed. END

Should We Legalize 'Mercy Killing'?

[*Continued from* 66]

and Obstetrics; Dr. George F. Lull, general manager of the AMA.

Public opinion seems to be almost evenly divided. A Gallup poll in Feb. 1950 showed 43 per cent in favor of legal euthanasia, 46 per cent opposed, 11 per cent undecided. Yet a mercy killer is seldom indicted, almost never convicted. The lay public, even if not preponderantly favorable to euthanasia, is apparently unwilling to condemn specific instances of it.

One phase of the problem is scarcely touched on in the vast literature of the subject. To wit: What would go through the mind of the doctor as he approached the patient, the fatal syringe in his hand? I have tried to imagine myself entering the room. Would I greet the patient at all? Could I do it without a sense of shame? As he looked up at me, smiling wanly, could I then press the plunger that would put him to death?

Most of the pro-euthanasia doctors I've queried have balked at this point. To a man, they've admitted that they couldn't do it either. But they've said they could always find another doctor who *would* do it.

Could they?

—HENRY A. DAVIDSON, M.D.

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CONVENIENT AUTOMATIC TIMER | MODERN APPEARANCE | MODERATE PRICE | HEAVY-DUTY CONSTRUCTION | ADEQUATE OUTPUT

Once you've used the remarkably convenient GE Inductotherm, you'll wonder how you ever got along without it.

First off, take the automatic timer . . . a convenient device that automatically shuts off the radiation just when you want it to, leaving you free to attend to your next patient. What's more, there's a patient-controlled pull switch that makes it possible for the patient to terminate treatment.

Then, there's the smart, modern styling that will complement any setting. In addition, the Model E Inductotherm has an output ample to elevate the patient's temperature to the limit of his tolerance, and sufficient for regional applications or the operation of a fever cabinet.

You'll be glad to know, too, that the initial cost of the Model E is surprisingly moderate. Yes, manufacturing efficiency makes possible the achievement of a new low price level. A saving that's passed on to you. And back of the Inductotherm stands GE's nationwide service and engineering — as near to you as your telephone. See your local GE representative for full details or write General Electric X-Ray Corporation, Dept. C-5, Milwaukee 14, Wisconsin.

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"The increases in hemoglobin were...

dramatic...rapid..."[1]

Independent controlled investigations continue to confirm the greater effectiveness and better tolerance of molybdenized ferrous sulfate (Mol-Iron) in the treatment of iron-deficiency anemia.

Typical findings:

"We have never had other iron salts so efficacious..."[1]

"More rapid... response than ferrous sulfate"[2]

"A true example of potentiation of the therapeutic action of iron."[3]

"Generally well tolerated... even in iron-intolerant patients..."[4]

1. Dieckmann, W. J., and Priddle, H. D.: American J. Obstet. & Gynec. *57*:541-546 (March) 1949.
2. Chesley, R. F., and Annitto, J. E.: Bull. Margaret Hague Maternity Hospital, *1*:68-75 (Sept.) 1948.
3. Healy, J. C.: Journal-Lancet *66*:218-221 (July) 1946.
4. Kelly, H. T.: Pennsylvania M. J. *51*:999 (June) 1948.

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—a specially processed, co-precipitated, stable complex of molybdenum oxide 3 mg. (1/20 gr.) and ferrous sulfate 195 mg. (3 gr.). Recommended adult dosage: 2 tablets, t. i. d. Available in bottles of 100 and 1000 tablets and in a highly palatable Liquid, in bottles of 12 fluid ounces.

White

LABORATORIES, Inc.,
Pharmaceutical Manufacturers, Newark 7, N. J.

AMA Readies Advertising Campaign

[*Continued from* 51]

40,000 inches of paid copy in 420 newspapers. An equal amount of tie-in advertising has hammered away at the same theme. This latter space has been donated by druggists, dairies, grocery stores, bowling alleys, even bars.

What's new about the AMA campaign is its massive scope. Clem Whitaker (who prepped for this drive by managing California's) expects the AMA message will also be bolstered by tie-in ads. These, he hopes, will echo the doctors' sentiments in space paid for by local drug companies, prepay plans, insurance firms, and the like. If the idea pans out, the impact of medicine's message will be doubled or tripled. But making the arrangements on a national scale will be no cinch.

To set the stage, Whitaker & Baxter will run explanatory ads in the advertising trade press: Editor & Publisher, Advertising Age, Printer's Ink, Tide, and such. These ads will (1) tell what the AMA is planning; (2) explain the reasons therefor; and (3) seek press cooperation in arranging tie-in ads.

What about the timing of the AMA campaign? Says Clem Whitaker:

"We didn't urge an advertising program last year because our chief job then was heading off compulsory health insurance. We didn't feel that advertising would help us in fighting a specific bill. But now—temporarily, at least—that legislation has been stopped.

"This year our chief job is selling a product: voluntary health insurance. We believe advertising is a good way to clinch the sale."

Adds the AMA publicist: "If we can get the American people to think of prepaid health care as a budget necessity—just like life insurance—the doctors' money will have been well spent."

According to W & B estimates, two Americans out of every three have not yet been reached by the doctors' pamphlet campaign. Chances are, the forthcoming ads will catch many of them. Possibly the average reader of The New York Times or The San Francisco Examiner already knows about voluntary health insurance. But the

pain!...

To obtund pain without recourse to narcotics – yet better than the patient's medicine cabinet can – becomes a daily professional obligation. That's why Phenaphen was formulated with calculated pharmacologic precision . . . the analgesic action of its aspirin-phenacetin components being implemented and prolonged by its phenobarbital content (which helps allay apprehension) . . . its hyoscyamine further increasing overall efficiency through local anodyne action. Phenaphen—the astute professional prescription for pain—is promoted to physicians only.

the synergic formula for maximum non-narcotic analgesia

Each tablet or capsule contains:

Phenacetin (3 gr.)	**194 mg.**
Acetylsalicylic Acid (2½ gr.)	**162 mg.**
Hyoscyamine Sulfate	**0.03 mg.**
Phenobarbital (¼ gr.)	**16.2 mg.**

phenaphen®

A. H. ROBINS CO., INC. **RICHMOND 20, VA.**
ethical pharmaceuticals of merit since 1878

AMA ads may do much good among readers of small-town papers like the Henderson (Ky.) Gleaner, the Arkadelphia (Ark.) Siftings-Herald, the Lubbock (Tex.) Avalanche-Journal, the Winnemucca (Nev.) Humboldt Star. The strength of the AMA campaign lies in its blanket coverage.

What specific results can doctors expect in return for their $1 million? Here is one man's opinion:

¶ Increased public awareness of existing prepay plans. This may be reflected to a marked extent in increased enrollment.

¶ Increased Congressional exposure to the idea that voluntary plans *can* meet the need. Coming at the height of the fall political campaigns, this may have wide repercussions.

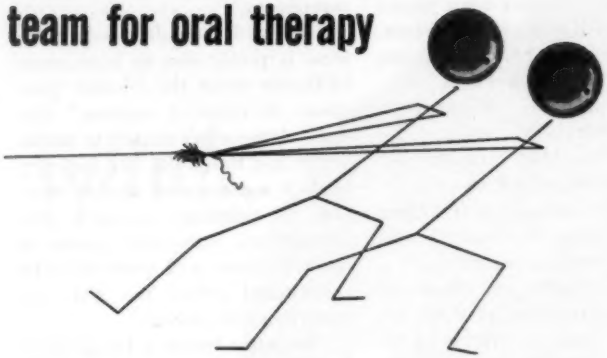
Along with these dividends, medicine is pretty sure to reap some kickbacks about the alleged "purchase of editorial opinion." But these claims won't amount to much.

For one thing, the vast majority of U.S. newspapers already support the voluntary approach. For another, the remaining papers—or most of them—will probably take their stand before the AMA ad campaign gets started.

This latter course is being urged by Editor & Publisher. "Then," says this respected trade bible, "the critics won't have anything to talk about. They can smother in their own indignation." —MELVIN SCOTT

"I weigh exactly the same as Linda Darnell!"

team for oral therapy



The daily administration of one or two Tablets MERCUHYDRIN® with Ascorbic Acid usually produces adequate diuresis in the cardiac patient whose water and electrolyte balance *has already been stabilized by parenteral mercurial diuretic therapy*. At this stage, the edema-free state – manifested by the unfluctuating basic weight – can be maintained with the tablets, either alone or supplemented by injections at appropriate intervals.

Such a schedule now gives time-honored digitalis a worthy partner in the fight against the failing heart. Maintaining the cardiac patient free of signs and symptoms of failure is facilitated by dual oral therapy – MERCUHYDRIN Tablets with Ascorbic Acid teamed with oral digitalis preparations.

tablets

MERCUHYDRIN

with Ascorbic Acid

(Brand of Meralluride)

The systematic use of MERCUHYDRIN Tablets with Ascorbic Acid simplifies treatment for patient and physician – injections are considerably reduced or eliminated, and visits to the physician's office are kept to a minimum.

packaging

Tablets MERCUHYDRIN with Ascorbic Acid, available in bottles of 100 tablets. Each tablet contains meralluride 60 mg. (equivalent to 19.5 mg. mercury) and ascorbic acid 100 mg.

Lakeside Laboratories, INC.

MILWAUKEE 1, WISCONSIN

Your Liability In Accident Cases

[*Continued from* 55]

court said, "If he undertook to treat the ailment, his responsibility is not dependent upon an agreement of employment or promise to pay. There is no reason why the degree of care should be less when services are gratuitous."

Generally, the doctor need not continue with an emergency case beyond the first treatment. But in this first meeting, the doctor-patient relationship is fully invoked.

Example: A woman hit by a taxi was examined by a physician at a nearby hospital. Later called to testify for the cab company, the doctor was asked to describe her condition. The patient's attorney protested that under Washington law (the same applies in many other states) such an examination was confidential.

The court agreed. The doctor-patient relationship, it said, was not dependent on actual treatment. The relationship is implied if the physician makes an examination with the patient's consent when the patient has reason to believe that he'll receive treatment.

In any accident case, note-taking is a bulwark against legal complications. A complete history may be hard to get, but the doctor's records should include all immediate details—apparent extent of injuries, number of stitches, type of dressings, etc. He will then be able to justify his actions.

—MILTON TOLMACH, LL.B.

Making the most of what you have or:

half of knowledge is knowing where to find it

THIS IS THE BLUE SECTION

—THE THERAPEUTIC INDICATIONS INDEX—

in your

P D R*

GRANULOMA INGUINALE
Chloromycetin (Parke, Davis), p 456
Faudin (Winthrop-Stearns), p 521
Merck & Co., Inc. (Dihydrostreptomycin Sulfate), p 449
Merck & Co., Inc. (Streptomycin Calcium Chloride Complex), p 451
Rexall Drug Co. (Streptomycin), p 468
Squibb, E. R. & Sons (Dihydrostreptomycin Hydrochloride), p 500
Squibb, E. R. & Sons (Streptomycin Hydrochloride), p 503

GRAVE'S DISEASE
(see under Goiter—this Section)

GRIPPE
(see under Influenza—this Section)

GROWTH—DEFICIENT
"A.P.L." Brand of Chorionic Gonadotropin (Ayerst, McKenna & Harrison) p 419
Allbee Capsules (Robins), p 478
Allbee w/Vitamin C Capsules (Robins), p 478
Amiprote (U.S. Vitamin), p 506
Apestrin (Harrower), p 437
Aquasol A Drops (U. S. Vitamin), p 506
Aquasol A & D Drops (U. S. Vitamin), p 506
Betaplexin (Winthrop-Stearns), p 520
Betaxin (Winthrop-Stearns), p 520

your up-to-date index to ethical drugs

You've diagnosed the condition . . . it may or may not be something you come across every day . . . but the drug you want is "just on the tip of your tongue."

You'll find it in the blue section of PDR under the indication for which you want it. For example, CHLOROMYCETIN is listed under 12 different therapeutic indications of which a few are GRANULOMA INGUINALE, RICKETTSIAL DISEASES, TYPHOID FEVER and UNDULANT FEVER.

The blue section leads you to the white PROFESSIONAL PRODUCTS INFORMATION section where you'll find all the data you need on the product in question—its COMPOSITION, ACTIONS AND USES, ADMINISTRATION AND DOSAGE, CONTRAINDICATIONS, HOW SUPPLIED. In addition, for your convenience, there is an ALPHABETICAL INDEX by company and product—the pink section, a DRUG AND PHARMACOLOGICAL INDEX—the yellow section, and GENERAL PROFESSIONAL INFORMATION—the green section.

Spend a short time with your PDR *now*, and you'll be sure to save lots of time later.

*PDR—Physicians Desk Reference

PUBLISHED BY *MEDICAL ECONOMICS, INC.*, RUTHERFORD, N. J.

Dynamo

[*Continued from* 70]

during his wartime service in New Guinea. He began to wonder about its genesis. When he got back to the U.S., he tried to find a good history of chess—and couldn't. So he wrote one. The end product, published this spring, is an astonishing potpourri of answers to such questions as "Why is the queen more powerful than the king?" and "Why is the bishop a courier in Germany, an elephant in Russia, but a fool in France?"

Henry Davidson went into the private practice of psychiatry in 1931. "I had a lot of free time," he says. "It was a depression year—remember? Somehow, I got mixed up in writing activities and community affairs. I've never been able to disentangle myself."

His current entanglements cover a lot of ground. Among other things, he's vice president of the New Jersey Welfare Council; a committee chairman for the American Psychiatric Association; and a faculty member at Jefferson Medical College. These, too, are spare-time activities.

During his hitch in the Army, he discovered that he liked administrative work. "I actually enjoyed hacking my way through the jungle of circulars, bulletins, and regulations," he says. Since his private practice didn't offer much in the administrative line, he switched to Government service after the war. Today he is neuropsychiatric chief of the V.A.'s regional office in New Jersey.

A day in the life of Davidson makes the ordinary mortal gulp. In rural Hunterdon County, N.J., where he lives with his wife and two children, his alarm goes off at 5:30 each morning. After a light breakfast, he swings aboard the 6:44 at Flemington Junction. During the hour-long train ride to Newark, he works intently at his Army correspondence course (he's studying to be a lieutenant colonel). He's at his V.A. desk by 8.

For the next nine hours, his energies belong mostly to Uncle Sam. During lunch hour, he takes time out for a shoeshine—often simultaneously working out a quadratic equation in his head ("It improves my mind"). By 5:30, when he boards the homeward-bound train, he's ready for an hour of nothing but thinking. Not much else he *can* do, since he has to stand all the way.

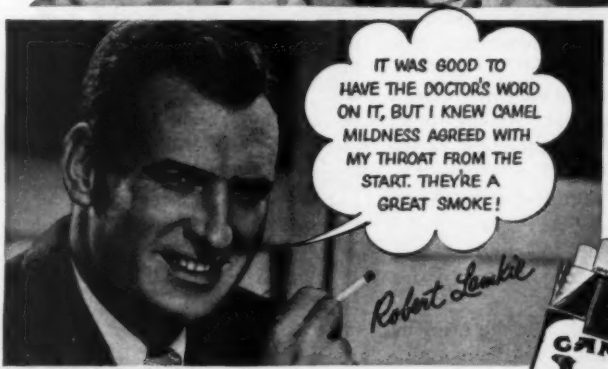
By 8 P.M. he's reached home, had dinner, and cleared for action. Now come two hours of high-speed typing. In a typical evening, he hammers out half an article, rips through one or more committee reports, and answers half a dozen letters. Curfew comes at an inflexible 10 P.M.

In all this he displays a fierce passion for system and order. "I

THROAT SPECIALISTS REPORT
ON 30-DAY TEST OF CAMEL SMOKERS:

"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.



ROBERT LAMBE
Personnel Director
One of hundreds of people from coast to coast who made the 30-Day Camel mildness test under the observation of throat specialists.

R.J. Reynolds Tobacco Co., Winston-Salem, N. C.

ACCORDING TO A NATIONWIDE SURVEY:

MORE DOCTORS SMOKE CAMELS

THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.

consider any bit of information that comes across my desk potentially useful," he says. "I file it whether it's a pamphlet on how to keep your cellar dry or a summary of the last Olympic games. You never can tell when it'll come in handy."

Thanks to this love for detail, he can reel off all manner of statistics on his own career. "In the course of a year," he'll tell you in his explosive, 300-words-a-minute style, "I deliver twenty public speeches, write fifty editorials or articles, ride 24,000 miles in trains, attend thirty-five committee meetings, bring home fifty layer cakes from the city bakery, and tell 600 doctors over the phone that the V.A. can't give outpatient or clinic treatment to their non-service-connected cases."

Talking with a friend not long ago, Henry Davidson wrapped his zest for life into a neat capsule. "I have the fortunate talent," he said, "of never being bored. It seems to me there's something interesting in everything.

"If a patient tells me (as one did yesterday) that he's attending a school of tailoring, I like to discover just how they teach that trade. I let the insurance agent tell me how he goes about selling insurance. I let the architect tell me how he figures the cost of a new building.

"The other day, a Spanish-American war veteran who had been born in Scotland told me that in his youth you could solemnize a temporary marriage in the Highlands by holding hands, and that this was called 'handfasting.' Well, some day, somewhere, somebody is going to say to me: 'I don't suppose you ever heard of handfasting . . . And I'll be able to say slowly: 'Well, as a matter of fact. . .'"

Among the lesser Davidson talents is a knack for writing off-beat poetry. His most famous verse won't get into any anthologies, but it caused quite a stir when published in a New Jersey newspaper. At the time (1943) Major Davidson was sitting sadly under a coconut palm in New Guinea. "Until that moment," he says, "I had considered myself so thoroughly urbanized that a picnic in the park always seemed like an afternoon of primitive hardship." Here are the deathless lines that enshrined his sentiments for posterity. As you might guess, they were written in fifteen minutes flat:

The ads say it's terrific
To sail the blue Pacific,
To see the world in freighters or
in tramps;

But eating mangoes or papaya
Out in Fiji or Hawaii
Gives me nothing but a bellyache
and cramps.

So take your isles romantic,
In Pacific or Atlantic,
Where the vegetation's tropical
and lush;

Get me back where it is noisy,
'Mid the factories of Joisey,
With a bathroom where the toilets
really flush. END

The Analgesic **BAYER ASPIRIN** *for Home Use*

BAYER *Genuine*

Now in Convenient CHILDREN'S SIZE

GROOVED TABLETS EASILY BROKEN

UNCOLORED
UNFLAVORED
CAN'T BE MISTAKEN FOR CANDY!

2½ grs. 1¼ grs.

Thirty 2½ grain Tablets 25¢

Write for a package

The BAYER COMPANY DIVISION • 170 Varick Street • New York 13, N. Y.
OF STERLING DRUG INC.

My Aching Practitioner

[*Continued from* 59]

decree. You were, for instance, a dermatologist if your commanding officer thought you looked like one (even though you had been a practicing orthopedist for eight years) or if the table of organization had room only for a dermatologist.

In Army hospitals the specialist alone had authority to answer questions about his specialty. If an officer in the general medical ward had a patient with psychoneurotic complaints referable to the cardiovascular and urological systems, he asked for cardiac and GU consultations prior to NP evalution. Then, through a series of transfers, this same officer, often as not, rotated through these three services just in time to answer the consultations he had requested—after the manner of Pooh Bah, in "The Mikado," the nature of whose advice depended upon his official capacity at the moment.

It Pays to Be an Expert

Medical schools extol specialization to the student. The lecturer on the common cold is not the G.P. who sees fifty cases a week but someone who knows the pH of the nasal mucosa.

John Q. Patient helps the trend along by being willing to pay five times the G.P.'s fee to have a specialist assure him he's getting the right treatment. He's glad to pay for his conviction that his is a unique duodenal ulcer which no one but a duodenal ulcerist can really appreciate.

The specialist's first goal is not diagnosing the case but deciding whether it falls within his purview. He is loath to speculate on the symptoms, if not in his own field, for fear of trespass. It thus becomes either heresy or a luxury to have symptoms referable to more than one specialty.

A Fraction of a Patient

If the trend continues, patients will no longer be looked on as individuals, but as anatomical mosaics. Doctors will be in the position of the seven blind men who tried to describe an elephant.

By present ground rules, a G.P. is one who can treat a cold, will take night calls, has a phone and a directory of medical specialists. This assumes that the cold does not last more than a week and has no psychiatric, otolaryngological, or allergic implications.

A point of contention between the G.P. and the specialist is the discrepancy of fees. If the G.P. gazes north through a proctoscope, he is doing his routine duty; if the specialist does the same thing, he is engaged in a "procedure." The result is that the G.P. can't afford to be exhaustive, the specialist

can't afford to see the patient for less than $10 a visit.

The specialist often reaps the glory of the G.P.'s work. The low man on the totem pole decides that a child howling at 4 A.M. doesn't have just an overdose of popcorn and hot dogs, but an acute appendicitis. He calls the surgeon, who orders a blood count and rolls back into bed. In the morning he does an appendectomy, more or less at his leisure. To the anxious parents, he is the man who is their child's savior—this at twenty times the fee of the man who diagnosed the case.

A specialist can expect advancement in a hospital or medical school no matter how low he starts. He may begin as a mere assistant clinical assistant (medicine's equivalent of water boy, for those with no relatives on the board of trustees) and his chief may be the ward girl in charge of urinals. Yet, if he lives to be 170, he will attain seniority and become a professor or chief of service.

How Can a G.P. Specialize?

A specialist gains rank by increasing his specialization. Not so the G.P. For how general can a general practitioner become?

A hospital would show no hesitation in making a physiologist chief of medicine, even though the last time he had seen a patient was as the only M.D. aboard a plane in which a woman went into premature labor. But if a G.P. with twenty-five years' experience were appointed to take temporary charge of the alternate Tuesday 2:45-3:00 P.M. medical clinic, every interne with six months of internal medicine would feel affronted.

The point is made that the specialist has more training than the man in general practice. True, but not necessarily logical. Does the essence of education really lie in knowing more and more about less and less? Wouldn't there be a certain rationale in demanding that the family doctor take ten years of p.g. training, the internist five, with only one year required of the man who's going to devote himself solely to fenestration operations?

To Each His Own

Whatever the answer, specialization will no doubt continue to take a fat share of the man-hours given to medical training. And specialists will continue to over-specialize.

In the Army, teams of M.D.'s examined large groups of soldiers prior to overseas shipment. One practitioner would look at hands; another at eyes; another at the throat; and so on.

A doctor in one such team was assigned to give each G.I. a proctologic check. After several thousand inspections, he began to wonder what he could find in his prescribed area that might conceivably prevent a soldier from going overseas at that crucial moment of the war. He resigned himself to watching for a square anus.

—THEODORE KAMHOLTZ, M.D.

reliable, convenient, versatile, palatable

3 new

water-soluble liquid vitamin preparations

Potent, economical and pleasant tasting, these three new vitamin preparations are ideally suited for routine supplementation of diets of infants, children and adults. ¶ They may be dropped directly into the mouth, stirred into the formula, or mixed into cereals or other foods. ¶ Each is supplied in 15 and 50 cc. bottles, with an appropriately calibrated dropper to assure accurate dosage and facilitate administration.

POLY-VI-SOL

Each 0.6 cc. supplies:

Vitamin A	5000 USP units
Vitamin D	1000 USP units
Ascorbic Acid	50.0 mg.
Thiamine	1.0 mg.
Riboflavin	0.8 mg.
Niacinamide	5.0 mg.

TRI-VI-SOL

Each 0.6 cc. supplies:

Vitamin A	5000 USP units
Vitamin D	1000 USP units
Ascorbic Acid	50 mg.

CE-VI-SOL

Each 0.5 cc. supplies:

Ascorbic Acid	50 mg.

MEAD'S

MEAD JOHNSON & CO.

EVANSVILLE 21, IND., U. S. A.

The Newsvane

Cheesecake Nourishes Blue Shield Plan

To glamorize its recent San Diego membership drive, conducted jointly with Blue Cross, the California Physicians' Service (Blue Shield) borrowed a page from Hollywood and the home-permanent people. Gorgeous twin sisters, "Miss Blue Shield" and "Miss Blue Cross," for two weeks cavorted in scanties across billboards and the picture sections of the local press. San Diegans goggled, then flocked in such numbers to plan offices that additional enrollment quarters had to be opened. San Diego newspapers, not always friendly to CPS, conceded that the doctors had finally hit upon a constructive, "positive" approach to voluntary health insurance.

Humphrey 'Off Beam,' Says Fishbein

In Minneapolis a month ago, Dr. Morris Fishbein told reporters that he is for the Taft Health Bill, with modifications. Dr. Fishbein said that the only solution of the medical-indigent problem is Federal grants to states and, through the states, to communities.

The ex-AMA editor was sharply critical of Senator Hubert H. Humphrey (D., Minn.) for his support of nationalized medicine. "I'm surprised that he is so far off the beam," said Dr. Fishbein, "in view of his druggist's training."

Term Tax Credits for Premiums a Delusion

It's one of Capitol Hill's perennials: the proposal that Congress amend the income-tax laws so that medical prepayment plan subscribers may deduct a percentage of premiums in making tax returns. In a current bill, H.R.6819, introduced by Rep. Kenneth B. Keating (R., N.Y.), taxpayers with an income of $2,000 or less could take credit for 90 per cent of their sickness-insurance premiums; those in the $2,001-$4,000 bracket, 85 per cent; and so on up to those with incomes of more than $10,000, who would be allowed to take 60 per cent deductions.

Would this promote the sale of sickness insurance among families that need it most? Some Washington observers last month didn't think so. Their reasons:

About one-third of U.S. wage-earners have annual incomes of $2,000 or less. For these people, in-

come tax concessions hold little interest since normal exemptions reduce their income taxes to the vanishing point anyhow.

A large section of the low-income group is made up of pensioners, who are ineligible for sickness insurance. Still another section is composed of farm workers, who have no access to it. A third segment consists of young workers who don't want it.

Thus the low-income group, which it is argued, needs sickness insurance most, is the least promising market for it; and no minor financial come-on such as income-tax rebates can improve that market. But big savings would be affected by persons in the middle- and high-income groups who can pay for prepayment insurance without such aid.

Critics of the plan also observe that the Government's diminished tax returns would have to be offset. The average taxpayer would thus probably wind up with an attractive deduction, a higher tax rate, and about the same remittance he had been making right along.

Well, Maybe There's a Moral in It

In a letter published recently by the San Diego Tribune-Sun Union and addressed to that newspaper's legal-problem columnist, "Rosalyn R." posed this question:

"I was being treated for a heart condition by a specialist. After a careful examination he said to me: 'Your legs are somewhat swollen, but that doesn't worry me in the least.'

" 'It wouldn't worry me either if your legs were swollen,' I cracked right back at him. He seemed miffed. Was I right?"

"No," replied the columnist, "he was only trying to reassure you. You misunderstood the situation, like the woman who saw two repairmen climbing telephone poles ahead of her on the road. 'Fools,' she hissed. 'They must think I never drove a car before.' "

Truman Bills Enacted by 'Sneak Thrust'

The hidden-ball play has been used by the Administration in pushing piecemeal legislation that could eventually add up to nationalized medicine, observes Ray Tucker, Washington columnist. He cites Senate action on the Emergency Professional Health Training Bill and the National School Services Bill.

"Both measures," he says, "were called up in the Senate when only a few members were in their seats, and they were whooped through without a roll call. Their titles were read in a mumble-jumble monotone by the reading clerk but their purpose was not explained in detail. It is doubtful if more than a handful of Senators realized that they had passed two of the medical

measures most dear to Administration advocates of the so-called welfare state. Ironically, only a few members of the American Medical Association understood the significance of these bills."

Stassen Decries Chains on Free Enterprise

Physicians opposed to nationalized medicine are cheering a forthright declaration by Harold E. Stassen, rejecting "me too" liberalism in the Republican Party. Says the ex-Governor of Minnesota:

"The economic freedom of man—that is, his freedom to buy and to sell, to work and to profit . . . to save and to spend, subject only to broad and fair rules of the economic road—cannot permanently be divided from his other freedoms. If a man becomes subservient to the men in authority in his government . . . for where he may work and what he may earn, for what he may produce and how he shall profit

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.

The fluid sulfadiazine that

tastes better!

acts faster!

Children—and adults who balk at bulky sulfadiazine tablets—take ESKADIAZINE willingly because of its delicious taste and pleasant consistency.

Instead of ordinary sulfadiazine, ESKADIAZINE contains S.K.F.'s *microcrystalline* sulfadiazine in a stabilized suspension. Result: desired serum levels may be attained *3 to 5 times more rapidly* with ESKADIAZINE than with sulfadiazine in tablet form. Each 5 cc. (one teaspoonful) contains 0.5 Gm. (7.7 gr.) of sulfadiazine—the dosage equivalent of the standard sulfadiazine tablet.

Smith, Kline & French Laboratories, Philadelphia

Eskadiazine

the outstandingly palatable fluid sulfadiazine

. . . then he cannot truly be free in what he may say or write, or how he may worship, or how he may live."

Mr. Stassen, president of the University of Pennsylvania and a Republican Presidential aspirant in 1948, warns his party that it must rally public support on the "issue of true freedom." Addressing the Illinois Young Republican Federation, he declared:

"Let us make clear that if people are looking for a political party that will promise to everyone ever-larger handouts from the public treasury, they should look elsewhere; that we hold the public treasury is in reality the people's pockets; and that we will not seek to win votes by false promises or by leading the country down the road that inevitably ends in a cheapened dollar and ultimate misery and suffering for all when resources are drained."

How to Do Right By Your Office Lawn

Everyone knows his home or office lawn needs plenty of water to keep it from frying to a crisp in the summer sun. But according to a recently published booklet, "How to Water Your Lawn . . . Right," most people are green as grass in the gentle art of lawn-sprinkling. Some tips:

¶ For best results, take to your hose in the early morning. This gives the water time to soak into the ground, fortifies the lawn against the heat of day.

¶ An occasional two-hour soaking is better than daily surface sprinkling. Ground should be kept moist to a depth of six inches.

¶ Oddly enough, grass under trees requires more water than that in the sun, since roots gulp up much of the moisture.

¶ Slopes, because of drainage, need more frequent sprinkling than level areas.

The booklet also offers hints on the special drinking habits of various soils and grass species. It may be obtained gratis from the Scovill Mfg. Co., Waterbury, Conn.

More Plans Accepting Solo Subscribers

An encouraging sign for voluntary health insurances, says Dr. Paul R. Hawley, former Blue Cross-Blue Shield chief, is the rapid increase in individual enrollment privileges among these plans. Today, forty-six out of sixty-three Blue Shield plans, and seventy-five out of eighty-four Blue Cross plans, accept individual membership applications, or soon will.

Asks Federal School for Physicians

A "West Point of Medicine," providing full training at no expense to carefully selected medical candidates, is again being proposed to produce M.D.'s for Government

NOW- MORE ACCURATE VISUAL DIAGNOSIS IN THE EYE, EAR, NOSE AND THROAT

WITH THE NEW, IMPROVED

A.C.M.I. DIAGNOSTIC SETS

American Cystoscope Makers offers the medical profession the finest line of Diagnostic Sets in its entire history. These new sets incorporate the outstandingly important feature—exclusive with the ACMI ophthalmoscope—of a coated lens system, greatly increasing the amount of light transmitted, improving definition and clarity of the image, and eliminating halo, flare and ghost images.

Standard Set, Catalog No. 1106

STANDARD SET comprises ophthalmoscope head (with built-in color filter and aperture changer), otoscope head with 3 specula, medium battery handle and one spare lamp, in plush-lined case, with space for additional specula and tongue depressor.

Compact Set, Catalog No. 1107

COMPACT SET, for the practicing physician, includes ophthalmoscope head (with built-in color filter and aperture changer), otoscope head, 5 ear and 1 nasal specula, small battery handle and extra lamp. Additional space for tongue depressor and more specula.

Large Set, Catalog No. 1109

LARGE SET contains otoscope head, 5 ear and 1 nasal specula, ophthalmoscope head (with built-in color filter and aperture changer), large battery handle, 1 extra lamp, with provision in case for tongue depressor head, additional specula and lamp replacement.

Professional Set, Catalog No. 1111

PROFESSIONAL SET. This, the most complete Wappler set, incorporates an otoscope head with 5 ear and 1 nasal specula, tongue depressor head, ophthalmoscope head (with built-in color filter and aperture changer), large battery handle, extra lamp, and rubber bulb for insufflation.

AMERICAN CYSTOSCOPE MAKERS, INC.

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service. Such a medical school, says a recent statement in The Washington Star, would not only furnish personnel for the armed forces and other Federal agencies, but could provide physicians for the nation's shortage areas. It is suggested that each graduate, in return for free training, agree to remain in salaried Government service for a specified number of years, as do graduates of West Point and Annapolis.

Well, That's Washington —Always Giving Out

The doctors' pal—that's Senator Elbert D. Thomas (D., Utah), cosponsor of the Thomas-Murray-Dingell bill. Doubt it? Well, one of his constituents, a Salt Lake City physician, recently wrote to Senator Thomas, asking for twenty-five copies of S.1581. Here's the prize package he received:

Five thousand letterheads of the Senate Committee on Armed Services; five copies of S.1697; forty-three copies of S.1456; 279 copies of speeches by Senator Wayne Morse (R., Oreg.); twelve Senate notebooks; eight copies of a disembodied document called "P.S."; and ten (not twenty-five) copies of the bill the doctor wanted, S.1581.

Nationalized Credit Called a Menace

Bankers as well as doctors are facing the creeping paralysis of Federal control, according to F. Raymond Peterson, president of the American Bankers Association. Nationalization of credits, he says, is a necessary evil during depressions and wars, but it's economically unsound under normal conditions. What's more, he asserts, it "paves the way for a socialized nation."

Says Compromise Means Federal Control

Reject "socialistic" Federal aid to medical education, urges Dr. Joseph C. Bunten, president of the Association of American Physicians and Surgeons. "It is futile," he says, commenting on H.R. 5940, "for the American medical profession or any other group to seek 'acceptable compromises' on this measure. As long as the bill provides Federal subsidy of medical education, it means eventual control of medical education by the Federal Government."

Says G.P.'s Get Poor Basic Education

A radical change in the system of training students for general medical practice is long overdue, says Dr. Arthur D. Woods, chairman of the Iowa Board of Medical Examiners. At present, he contends, the student is improperly trained to deal with most illnesses. This inadequate basic training has contributed largely to the growth of specialism, Dr. Woods believes.

Addressing a recent meeting of

the Federation of State Medical Boards in Chicago, Dr. Woods recalled that sixty years ago the lecture system prevailed in education. Then, he said, Dr. William Osler made his "greatest contribution to medicine": inauguration of the ward system of teaching.

"But what," asks Dr. Woods, "of the vast array of human complaints that need no bed, in ward or elsewhere? What are medical students being taught regarding the care of this great multitude—this 85 per cent who are never seen in a ward?"

Academicians are inclined to shrug off such problems, says Dr. Woods, and concentrate on the 15 per cent of patients whose illness has reached an acute stage. Yet, he points out, as long ago as 1920 Sir James McKensie wanted students taken out of the wards and put into the out-patient departments.

It is there, Dr. Woods believes, that the study of disease should begin. "It is there, and in the offices of general practitioners and in the home, that we find the great multitude of human complaints, the 85 per cent." He concurs with Dr. McKensie that the most difficult problem of medicine is the discovery of incipient disease. He believes that "the best brains on the faculty" should be found in the out-patient departments of teaching hospitals, and deplores the fact that many clinicians consider the work beneath their dignity.

This condition persists despite dramatic advances in prophylactic medicine, says Dr. Woods. Forty years ago, he recalls, mastoid abscess was common in hospital wards. Today it is controlled before any need of hospitalization develops. It is notable, he observes, that physicians find these incipient cases among ambulant patients, not in hospital wards.

HIP Goes Into Fourth Year of Operation

Recently celebrating its third birthday, the controversial Health Insurance Plan of Greater New York claimed to cover 231,000 people. Of these, 200,000 were municipal employes and their dependents. All are given full medical and surgical care by twenty-eight groups of physicians, numbering 800 in all. Largely because it restricts freedom of choice, HIP has yet to win the blessing of organized medicine in New York.

Get $75,000 Grant for Education Survey

The first all-out survey of U.S. medical education in forty years—conducted jointly by the AMA and the Association of American Medical Colleges—has been given impetus by a $75,000 grant from the W. K. Kellogg Foundation, Battle Creek, Mich. Alan Valentine, president of the University of Rochester (N.Y.), is chairman of the survey committee.

Survey topics include (1) stand-

ards for measuring potential medical students; (2) the influence of specialization on general practice; (3) how well schools are meeting the demand for physicians; (4) evaluation of post-graduate training; and (5) the affiliation of outlying hospitals with medical schools.

Check Five Diseases in One Screening

Mass screening tests for several diseases at once are now practicable, says Dr. C. Kelly Canelo of San Jose, Calif. Dr. Canelo reports on one such project, sponsored in San Jose by the county medical society, and the city and state health departments. Aim was to test multiphase screening for (a) saving of time and money, (b) more effective protection of the public.

The screening covered 945 employes of a department store, two units of a food company, and a paper-label factory. A survey team at each plant took brief histories, obtained urine and blood specimens, took miniature chest X-rays. Tests for diabetes, heart disease, nephritis, syphilis, and tuberculosis followed.

The results indicated, says Dr. Canelo, that "about 10 per cent of an apparently well population would be referred for definitive diagnosis. Approximately one out of three referred persons would be found, on a follow-up, to have a disease requiring continued medi-

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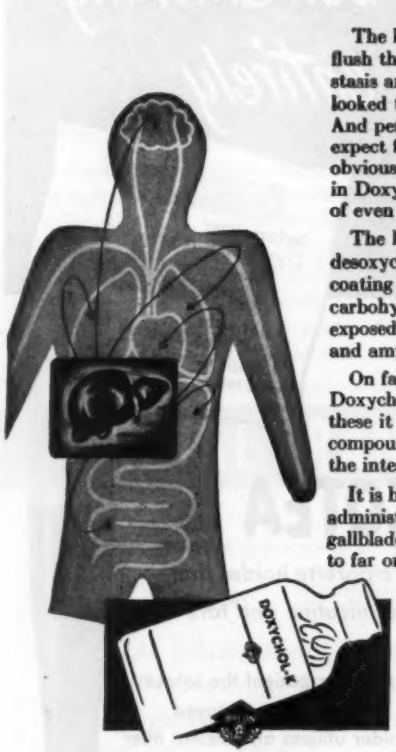
not *Over*looking other Structures



The bile acids are expected to drain and flush the biliary tract; to bring help against stasis and cholecystitis. Too, they are looked to for the vital digestion of fats. And perhaps these benefits are enough to expect from one agent. But truth is, the less obvious effects that flow from the bile acids in Doxychol-K may be for some patients of even greater importance.

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It is by these activities that Doxychol-K administration reaches beyond an impaired gallbladder, to bring better nutriment to far organs.

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cal care. In about half the cases, this disease would have been previously unrecognized."

Urges Change In Rules For DP Physicians

In a report before the Federation of State Medical Boards, Dr. Alexander M. Burgess of Providence, R.I., has urged that the rules governing licensure of displaced physicians be modified without lowering standards. The problem, according to Dr. Burgess, is to select those qualified to enter private practice or do public health, laboratory, or institutional work. In his opinion, not more than 10 per cent are ready for immediate practice here without becoming professionally and socially acclimated.

"The lack of familiarity with customs and usages has led many a foreign physician to make errors in dealing with patients and colleagues," he says. "This has been particularly true in the past, when the average doctor who escaped to this country was not of as high a type as has been coming to us in the last two or three years."

Dr. Burgess believes one answer lies in DP training programs similar to that in Iowa. The Corn State's Board of Medical Examiners approves the appointment of newly-arrived foreign doctors as assistant physicians in six state institutions. Their future course is taken up at the end of a year.

Other Burgess recommendations:

¶ Certificates of the International Refugee Organization should be accepted as evidence of graduation in medicine.

¶ Restrictions should be lifted on licensure of European physicians who have graduated in the last ten years and who have IRO's stamp of approval.

¶ The twenty-two states in which foreign graduates are not accepted should revise this restriction.

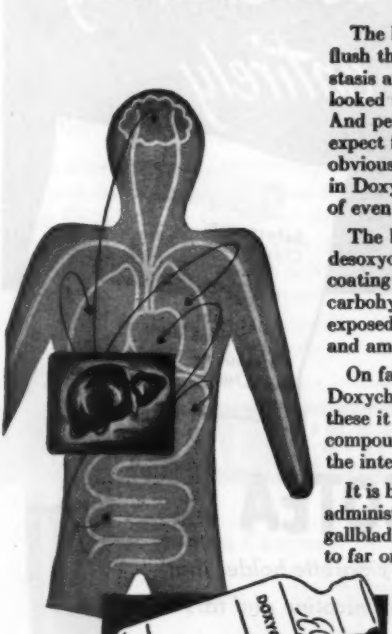
¶ State medical boards should look into the possibility of using their facilities for orienting and training DP physicians.

Full Industrial Care 'Good Business'

It's enlightened self-interest for industry to provide complete medical, surgical, and dental care for employes and their dependents without asking them to contribute to its cost. This is the conclusion of the American Cast Iron Pipe Company, Birmingham, Ala. Its medical director, Dr. D. O. Wright, recently told the Council on Industrial Health, AMA, that "Management feels that our employes earn these benefits by their increased production; therefore it is not philanthropy, but good business."

This pipe company's 1,600 employes and their dependents get general and specialist care in a modern, air-conditioned building. The full-time staff is headed up by a medical director, three physicians, and two dentists. Fourteen part-

Looking at the Biliary Tree... not *Over*looking other Structures



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This pipe company's 1,600 employes and their dependents get general and specialist care in a modern, air-conditioned building. The full-time staff is headed up by a medical director, three physicians, and two dentists. Fourteen part-

time specialists conduct clinics twice a week. Ward care is provided in local general hospitals; but the employe may have a private room by paying the difference in rates. Common drugs are dispensed without charge. Glasses and special appliances may be purchased at reduced rates. Bed-confined patients get medical care in the home.

Says License Rebuff Cost Town $2,500

Already stung by public criticism for denying licenses to displaced European physicians, state boards face a new hazard—court action for damages. One village, Dale, Wis. (population 300) said recently that it had spent $2,500 to bring a young German doctor to the U.S. on the strength of the state board's statement that he'd be considered for an examination. The board replied that no such examination would be given until the AMA had completed its evaluation of European medical schools. Miffed, the village fathers of Dale were weighing a suit against the board to recover their $2,500.

Towns Assail Coddling of Relief Clients

"Chiselers and wastrels" are encouraged by state welfare people to look upon home relief as "a way of life." So say township officials in New York State, adding that "social uplift" workers in the State Welfare Department are responsi-

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ble. Resistance by towns to this extravagance, they say, is met by threats to withdraw state aid. Towns are currently reimbursed for 80 per cent of their relief expenditures. But the law provides that this aid may be withdrawn if the Welfare Department isn't satisfied with the manner in which funds are spent.

CMA Coaches Tyros in Medical Economics

A bi-monthly brochure on medical economics, to be distributed among medical students, interns, and residents, is a new project of the California Medical Association. CMA aims to teach young doctors how to get along harmoniously with their associates and with the public and to "indoctrinate them in the principles of free enterprise." The brochure will contain factual material on the economics and techniques of private practice; news and gossip; and an open forum in which young physicians and undergraduates may express their views.

U.S. May Crack Down on Pharmacists

Pharmacists have been warned to cease dispensing prescription-type drugs over the counter and to stop unauthorized refilling of prescriptions. The caution comes from drug-industry leaders, who point out that the Federal Government has the power to punish such violations and intends to use it. More than

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100 pharmacists, it is said, were haled before Federal judges last year on charges of violating the Food, Drug, and Cosmetic Act.

The direct-sale ban upheld by the Supreme Court, may work a hardship in many sections where pharmacists have long sold prescription-type remedies directly over the counter, industry attorneys point out. But local custom won't be recognized when Federal inspectors make arrests. Nor can a pharmacist plead ignorance of the law merely because the Government has not laid down any sharply defined rules about direct sales, except in the case of narcotics.

Diagnostic Service Offered at Cost

New York Hospital has taken the wraps off a nonprofit diagnostic clinic for patients at all income levels. Even those who can afford to pay more are billed only for the bare cost of services. The clinic renders no treatment, furnishes referring physicians complete diagnostic reports. Patients who have no doctor can take advantage of the clinic on their own initiative, later see a private physician for treatment if necessary.

Wants Collegians Told Facts of Medicine

Who paid the expenses of Sir James Stirling Ross, former official of the British Ministry of Health, when he lectured before American college

audiences on the virtues of British nationalized medicine? Says the Florida Medical Association: "It seems unlikely that England, in its present financial plight, is spreading the gospel to America at its own expense. Is it our tax money that is footing the bill?"

Sir James' tour suggests that the minds of college students are "a fertile ground in which the medical profession might sow its thoughts and principles," says the association. "Perhaps the AMA will want to send lecturers to colleges throughout the country."

Washington Tries Horse Trading in Hospitals

Economy in government is often a seesaw: Costs, lowered on one side, go up on the other. Witness Defense Secretary Louis Johnson's decision to close five military hospitals, curtail services in several more.

This maneuver would save $25 million a year. But 1,800 V.A. patients in the service hospitals would then be out in the cold. As a result, Congress would have to raise the ceiling on V.A. hospital beds, set by law at 131,000. Asking Secretary Johnson to hold up his order, the House Armed Services Committee last month was wrestling these questions: (1) Who, if anyone, would be hurt by closing of the hospitals? (2) How should the hospitals be disposed of, if and when closed?

Veterans organizations wanted the hospitals turned over to the

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IN RECENT YEARS, THE ESSENTIAL ROLE OF VITAMINS IN COMPLETE PARENTERAL FEEDING HAS BEEN NOTED[4,5,6] **4.** RICE, C. O., *et al.*: Parenteral Nutrition, Pre- and Postoperative Use of Glucose, Amino Acids and Alcohol (A Preliminary Study), Journal-Lancet, 68:91 (March) 1948. **5.** GOLDSMITH, G. A.: Importance of Vitamins of the B Complex in Clinical Medicine, So. Med. J., 39:485-94 (June) 1946. **6.** Stigmas suggesting various gross vitamin deficiencies and the recommended treatment as provided by the Council on Foods and Nutrition, J.A.M.A., 131:666-7, 1946.

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- ***5% Alcohol v/v, 5% Dextrose w/v in Saline with Vitamins***
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V.A. Some states and municipalities were also hungry for them.

Chances were that Congress would let Johnson have his economy cut, then vote more money for the V.A.

Doctors Said to Merit No Traffic Privilege

Don't violate the traffic laws even if you are on an emergency call, New Jersey doctors have been warned. In finding a Newark physician guilty of speeding, the magistrate declared: "I am advised by mature and experienced doctors that in no emergency are the few minutes saved by traveling at an excessive rate of speed of any decisive value in the final outcome of the case."

Hawley Asks M.D.'s to Protect Blue Cross

Blue Cross may lose out in the insurance field if subscribers continue to abuse their privileges, warns Dr. Paul R. Hawley, former chief executive officer of the Blue Cross-Blue Shield Commissions.

"Blue Cross," he says, "is wholly at the mercy of hospitals and doctors—largely the latter—and must rely upon them for protection against abuses. It is ordinarily the doctor who says when the patient shall go to the hospital, what services shall be given him, and when he shall leave . . . The Blue Cross patient may demand hospitalization as a luxury rather than as a neces-

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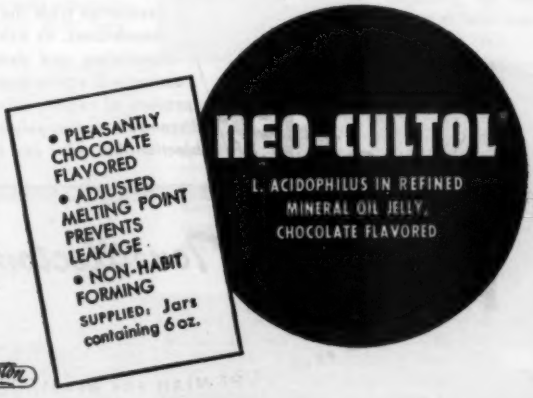

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sity. It is not easy for the physician to pit his own sense of right and wrong against a capricious desire of the patient."

The doctor, however, can and should enforce justifiable economy during a patient's hospitalization, says Dr. Hawley. Blue Cross, he adds, wants "every member to be given necessary service—and perhaps even a little more. But unless wholly unnecessary abuses are curbed, Blue Cross may be priced out of its most important market."

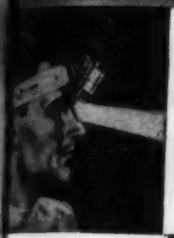
Residents and internes—as well as private practitioners—are sometimes responsible for unnecessarily high charges, Dr. Hawley asserts. Rather than be embarrassed by inability to answer a visiting doctor's question, he says, "the house staff often orders every conceivable test and roentgenography from the scalp to the toes. When a patient carries no insurance, due caution is usually exercised. But the Blue Cross patient is fair game. There is a curious defect in public morality which makes it no crime to gouge an insurance company."

Citizen Health Teams Gird for Action

To correct the community health problems on which socializers whet their axes, Texas doctors are spearheading the organization of a statewide network of citizens' health councils. These local groups—some fifteen in all—are to be led and coordinated by the recently-chartered

a smart move every time

Tens of thousands of doctors throughout America — and in many foreign lands, too — know by experience that National instruments are outstanding in functional efficiency and give long lasting satisfaction.



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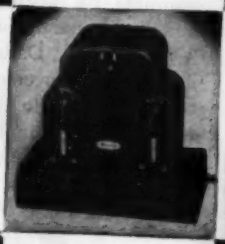

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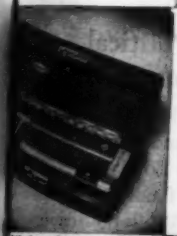

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Texas Health Council. Broadly, they'll shoot for increased enrollment in voluntary health plans and better distribution of moderate-cost medical service.

Drawing their strength from grass-roots support, the councils aim to enlist the aid of every Lone Star church, school, business, farm, newspaper, and other form of enterprise. Each council member is responsible for getting ten citizens into the campaign. Says Dr. George A. Schenewerk, Dallas surgeon and one of the movement's founders, "We propose to do by private enterprise what certain forces are proposing to do through the Government. We believe we can do it better than a bunch of politicians."

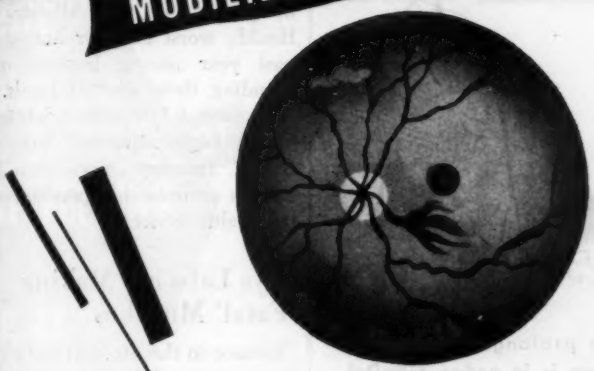
NHS Key to Political Struggle in Great Britain

The ding-dong battle between England's Labor and Conservative parties, say recent London reports, will probably turn finally on the national health issue. While both camps support socialized medicine in principle, Conservative guns have now found a vulnerable target in the cost of the scheme to the tight-belted isle. Sir Stafford Cripps' statement early this spring, calling a halt on further growth of NHS expenditures, sets the stage for a showdown, many observers believe.

"We must regard estimates of the coming year as the ceiling," Britain's Chancellor of the Exchequer told Parliament, "beyond which we must not be carried by

an effective agent to . . . .

MOBILIZE CHOLESTEROL



INOSITOL CSC

Accumulating evidence[1,2] is more firmly establishing the ability of inositol to reduce abnormally high blood cholesterol levels. This lipotropic agent activity has been demonstrated not only in patients with liver disease, but also in the presence of diabetes mellitus.[3]

Since hypercholesterolemia is regarded as a forerunner of atherosclerosis which in turn leads to local or generalized arteriosclerosis, inositol constitutes a sound weapon for the prevention or active treatment of degenerative arterial disease. Although the lipotropic activity of inositol is evident in the absence of all other therapy, the use of a high protein, low fat diet and the administration of other B complex vitamins is also advisable.

Inositol-C.S.C., supplied in 0.5 Gm. capsulettes, is indicated whenever lipotropic action of this substance is required. Average dose, 1.0 Gm. three times daily.

(1.) Felch, W. C.: New York Med. *5*:16 (Oct. 20) 1949. (2.) Leinwand, I., and Moore, D. H.: Am. Heart J. *38*:467 (Sept.) 1940. (3.) Felch, W. C., and Dotti, L. B.: Proc. Soc. Exper. Biol. & Med. *72*:376 (Nov.) 1949.

C.S.C. Pharmaceuticals

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new developments which cannot be provided out of economies in other directions."

The national budget, say British advices, is now strained to the breaking point. That makes it potentially the hottest of all political issues. Chief bogey of government budgeteers is the Ministry of Health, worst offender during the past year among bureaus overspending their allotted funds. Of the recent £170 million deficiency appropriation squeezed from the British Treasury, more than half was for unforeseen expenditures on the health service.

Says Labs are Making 'Fatal' Mistakes

"Menace in the Medical Labs" was the sensational headline that confronted readers of the April Woman's Home Companion. Under the title these readers found an even more upsetting blurb:

"Your health—even life itself—often depends on the skill and care of laboratory technicians serving your doctor or hospital. Many are wonder workers, indeed. But a nation-wide survey reveals a frightening increase in error and carelessness—a betrayal of trust that can kill."

The nation-wide survey had been conducted by Albert Deutsch, former columnist of PM and longtime critic of organized medicine. Mr. Deutsch had apparently gone to public health authorities for data on pathological laboratories, both

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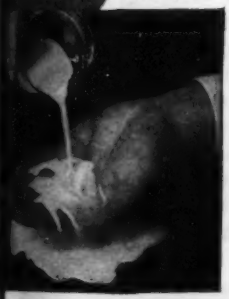

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public and private. His report, a ringing indictment, began as follows:

"When your doctor sends a specimen of your sputum, blood, urine, or tissue to a medical laboratory for examination, you probably share the delusion of most Americans that the laboratory report will be 100 per cent accurate on certain facts about what is wrong with you. Yet every year from 2,500,000 to 3,000,000 illnesses are wrongly diagnosed because of faulty laboratory tests."

And the medical profession is not without blame, said Deutsch: "Many physicians have been putting too much blind faith in the results of laboratory tests, sometimes with fatal consequences. Most of these laboratories are excellent. But too many operate on a substandard basis, committing fatal errors that could easily be avoided."

He quoted Dr. Karl F. Meyer, director of laboratories, University of California, as saying: "Most doctors don't realize adequately the limitations of laboratory tests in diagnosing disease. They send their specimens to the labs and expect to get a completely accurate report on the nature and prevalence of the disease organisms. The fact is that, aside from the many factors of human and mechanical error that enter into the picture, we just haven't developed precise standards of measurement in many diseases."

A disturbing number of the 300 million lab tests made annually in

this country are conducted by substandard laboratories, Deutsch contends. Some such labs, he says, are one- or two-room affairs operated by poorly trained technicians who are able to perform only the simplest tests. Often, he says, they are "young girls with little education, hastily trained for routine tasks."

Furthermore, he says, "a number of laboratory technicians and even medical technologists are turned out by profit-making diploma mills. It is amazing how little supervision public authorities exercise over these institutions."

Deutsch lashes out at the private physician who "hires a young girl —probably at a pittance—hastily teaches her the rudiments of a few common tests that he learned 10 or 20 years before, and sets her up as a 'laboratory technician.' Large numbers of misdiagnoses stem from such a set-up," he declares.

On the whole, he says, laboratory workers, from pathologists on down, are among the most underpaid and overworked of occupational groups. "This is especially true of technicians. They often work long hours for wages below those of unskilled laborers in their communities."

Greed sometimes raises its ugly head, Deutsch contends, with labs taking more work than they can properly handle. "The staff members are so grossly overworked that they are tempted to try shortcuts, neglect to recheck in doubtful cases, or rely on a single procedure when three or four procedures are

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required . . . To a shocking extent, hospital administrators tend to operate their laboratories as a source of profit or to subsidize other hospital activities. They are maintained on the skimpiest of budgets, are understaffed, and have insufficient modern equipment. In many hospitals, the lab pathologist must depend for help on medical internes and residents, who often regard lab work as a chore, not essential to their training."

As typical evidence of what he found in his investigation, Deutsch cites the following:

¶ The 1947 survey of "simpler" tests in 59 "better" laboratories by the Pennsylvania State Medical Society. "The results astounded the survey conductors. The range of error revealed was described as fantastic."

¶ A recent nation-wide survey by the College of American Pathologists. "The facts uncovered were so shocking that they have not been made public."

¶ A 1947 investigation of 17 diagnostic laboratories "near Chicago" by Dr. C. I. Reed, of the University of Illinois Medical School. "Posing as a patient, he had his basal metabolism rate determined at each laboratory. Only one-third of the labs arrived at an 'even reasonably correct' result."

¶ A 1947 report in the Journal of Laboratory and Clinical Medicine on a survey designed to determine the accuracy of lab tests for brucellosis. "This survey revealed that the

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majority of blood specimens were incorrectly analyzed."

¶ A recent survey by the USPHS in the Atlanta, Ga., area to test the accuracy of public health labs in diagnosing amoebic dystentery. "The reports received thus far show a wide range of error."

¶ Investigation by the Communicable Disease Center, Atlanta, Ga., of a "diphtheria epidemic" in a large Montana town. Two children had died of a disease diagnosed as diphtheria. Mass lab tests of persons living in the area indicated that a startlingly large number were hosts to diphtheria organisms. Entire families were quarantined, with wage-earners forced to go on relief. The CDC was invited to investigate, and found that the original smears contained, not diphtheria germs, but organisms resembling them that could have been identified with further tests. The quarantine was lifted and an incipient lynching of a suspected dairyman averted.

Dr. R. A. Vonderlehr, head of the Communicable Disease Center, recalled for Deutsch a USPHS investigation, made a dozen years ago, to determine the reliability of lab tests for syphilis. That survey revealed that some labs were detecting the spirochete in less than half the cases where it existed, and sending out positive reports on many syphilis-free persons. He added: "I am convinced that laboratory diagnostic errors *in many diseases* are just as common—or more so—today."

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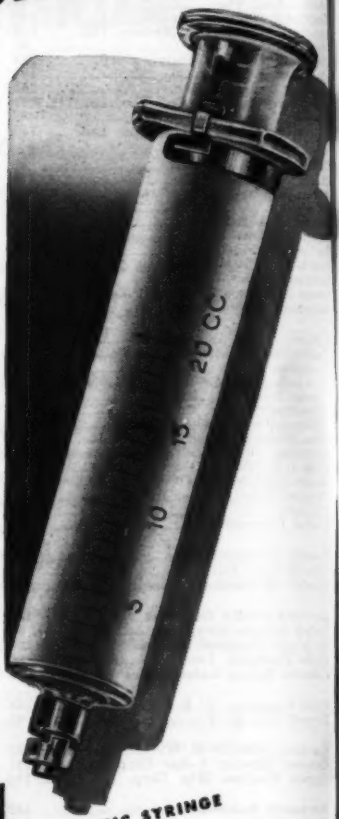

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